Nicole Scott

From: Michael Baker
Sent: Thursday, March 12, 2009 11:38 AM
To: Nicole Scott
Subject: CDI Contacts
Attachments: image001.png

The two friends that I mentioned as being interested in the CDI (possible presenters/facilitators/whatever else you can think of) are:

Chad Prosser: Chad.Prosser@autotrader.com (Master's in training and diversity issues)

Rabbi Joshua Lesser: RabbiJosh@gmail.com (Rabbi at Congregation Bet Haverim, I believe he has presented/panelled before)

They may or may not have the skills or time that you need, but I wanted to send it on to you.

Thanks!

Michael Baker
Director of Advancement
POSITIVE IMPACT
Positive Impact, Inc.
139 Ralph McGill Blvd., Suite 301
Atlanta, GA 30308
404.589.9040, extension 115
404.589.1615 (fax)
404.314.6166 (cell)
Michael.Baker@PositiveImpact-ATL.org

We have the power to change the myth. Everything is a myth.

Possible Facilitators for CDI

Dedra Cochran

From: Claire Hicks [chicks54@hemc.net]
Sent: Sunday, October 25, 2009 8:09 AM
To: Dedra Cochran
Subject: Re: Positive Impact Trainings

F/U with Dr. Hicks

HI, Dedra,
Thanks for getting in touch. I'd be delighted to be a presenter. What do you have in mind? It looks like I might fit best in the "cultural diversity" part--Claudia had mentioned that maybe I could talk about some of the social problems of our populations, and how we step out to meet them. How those problems influence their mental health, how their mental health influences their HIV, etc.

Friday will be OK. I just need to know as soon as possible what day it will be so I can get it on my schedule.
Thanks,
Dr.Hicks

----- Original Message -----
From: Dedra Cochran
To: chicks54@hemc.net
Sent: Friday, October 23, 2009 1:32 PM
Subject: Positive Impact Trainings

Hello **Claire**:

My name is Dedra Cochran and I am the Volunteer and Training Coordinator for Positive Impact, Inc. I was given your name by one of our staff members, **Claudia Becerra**, who serves as one of our **Latino Mental Health Counselors**. **Claudia** informed me that you would be a great person to facilitate one of our trainings for us. We offer Continuing Education and Training Credits to our staff, graduate interns and mental health professionals in an effort for them to gain knowledge and awareness about issues central to working with clients impacted by HIV/AIDS.

We have a variety of training topics that we will be facilitating throughout the 2009-2010 Program Year. Attached you will find a copy of the training topics staff are interested in attending. The trainings are scheduled from **November 2009 until August 2010, preferably on Friday's.** We typically have our trainings scheduled for Fridays because the majority of our staff has a full schedule with clients from Monday through Thursday and it is difficult to coordinate with everyone's schedule. However, if you are interested and a different day of the week will work better for you, we would be willing to try our best and accommodate.

We would be most gracious to have you as one of our presenters. I have attached a copy of our Mission Statement, which gives a little information about the purpose and importance of our organization. If you would like any additional information or have any questions, feel free to contact me via e-mail or phone at **(404) 589-9040 ext. 104**. Please let me know if you are available and interested and we could move forward from there. I look forward to hearing from you!

Sincerely,

Dedra Cochran

Dedra Cochran

From: Claudia Becerra
Sent: Thursday, October 22, 2009 2:59 PM
To: Dedra Cochran
Subject: Dr hicks

Cell phone for her
Dr Claire Hicks 912- 294-3020
email chicks54@hemc.net
I talked to her yesterday and she told me You can call her on her cell. She will be bale to tell you what topics she could help us with, she is a great MD and professional pluss a very interesting person.

Emailed: Request, mission, & training Calendar on 10/23/09

Nicole Scott

From: sol21@aol.com
Sent: Wednesday, April 15, 2009 4:26 PM
To: Nicole Scott
Subject: Re: Positive Impact 2009 Cultural Diversity Institute (CDI) Workshop 4/23 & 4/24

Hi Nicole,
Great image for the flyer. Glad things are falling into place and that you've been able to hang in there through the challenges.
I spoke with Rebecca Staple-Wax of the Rainbow Center at Jewish Family and Career Services and she is still away with her family for Passover break. She returns to the office on Friday and said she would fax you the info on Jewish resources. Should you not hear from her, feel free to give her a call: 770-677-9471.
The other piece from anyone who can't be there on Sunday is to let you know what will be needed re. handouts.
Best wishes,
Sarah

P.S. WIll there be any CEU's for psychologists? Let me know since that info would help me re. my professional liability insurance.

Sarah Lopez
1214 Poplar Grove Drive N. E.
Atlanta, GA 30306
404-876-2216

Sarah C. Lopez, Ph.D.
1778-B Century Blvd. N. E.
Atlanta, GA 30345
404-550-4136

-----Original Message-----
From: Nicole Scott <Nicole.Scott@positiveimpact-atl.org>
To: Paul Plate <Paul.Plate@positiveimpact-atl.org>; Sharon Kricun <KricunS@aidgwinnett.org>; Leon Morales <leon.morales@starinu.com>; mdvorak@golinharris.com; meghanmarino@gmail.com; Natasha Johnson <njohns7@emory.edu>; Paul Saros <pas1up@bellsouth.net>; Ruth Shim MD <rshim@emory.edu>; sandrakolka@comcast.net; Toni Ross <tross01@hotmail.com>; VMM918@aol.com; WljScubaMu@bellsouth.net
Cc: PI All <PIATL@positiveimpact-atl.org>
Sent: Wed, 15 Apr 2009 2:33 pm
Subject: Positive Impact 200
9 Cultural Diversity Institute (CDI)
Workshop 4/23 & 4/24

The Positive Impact
Education & Training Program will be providing a 2-day Cultural

Diversity Workshop hosted by, and for AID
Gwinnett staff at Hopewell Baptist Church in Norcross on

Thursday, April 23rd
9a-4p & Friday, April 24th 9a-3p.

Seats are limited and
first preference will be given to AID Gwinnett & Positive Impact staff

(*Please see the
attached flyer for additional information)

*There are a
few spaces reserved for additional participants who wish to attend this
training

(1or both
days)*

$90/2 days;
$45/1 day

10 CEU Hours
applied for from GSCSW & LPCA

Contact Nicole Scott at nicole.scott@positiveimpact-atl.org
or 404-589-9040 ext.104

if you have interest in
attending and/or require additional information!

Nicole Latty Scott, LMSW

Director of Volunteer Services
& Training

Positive Impact, Inc.

139 Ralph McGill Blvd.

Suite 301

Atlanta, GA 30308

404-589-9040 ext.104

nicole.scott@positiveimpact-atl.org

Cultural Diversity Institute

Panelists Questions

1. Please describe your work with the population you are focusing on today?

2. What brought you to that work? What is your connection to it and the people you serve?

3. Talk about some strengths. Use examples demonstrated by your population that you've learned about through your work with them.

4. What are some of the most pervasive and problematic myths related to HIV about your population that you would like to clarify?

5. When you think about the impact of HIV upon your group, what are the most significant trends that providers should know about? (HIV rates, other STD tests, lack of affordable housing, provider incompetence, erosion of reproductive rights).

6. How well does the health care system serve your group's HIV related needs? How does one's socioeconomic status/income level shape that experience?

7. Describe ways that cultural beliefs about sexuality, gender, and body image affect what your group believes, feels, about themselves?

8. What mental health issues do you see affecting your population? What resources, beliefs or support systems do people use to handle these issues?

9. How would you assess the effectiveness of services and resources that are available?

10. What is missing? What services or programs would you like to see expanded, eliminated, created, or changed that would help your population do better?

11. You have been given a blank check to develop a program that has 5 years to make a meaningful impact on your group. How could you engage the community you serve in the planning of this program? What do you think it would need to do?

Open the floor!!!

The Positive Impact 2009 Education & Training Program Presents:
The 2009 Cultural Diversity Institute (CDI)
Cultivating Cultural Competence: Engaging Multiple Identities, Challenging Oppression, Creating Effective Responses
Thursday, April 23 2009 9a-4p and Friday, April 24 2009 9am-3pm

AGENDA-DAY 1

Sign-In/Registration (*Please turn off all cell phones*)

Welcome-Paul Plate; Executive Director-Positive Impact

Overview of CDI & Expectations-Sarah Lopez

Color Exercise-Mollye Daughtry

BREAK

The Human Face of HIV:Conversations with Helping Professionals-Arlene Noriega

LUNCH

Oppression and Privilege-Malcolm Anderson

Internalized Oppression and Addiction-Mollye Daughtry and Jo Lewis

BREAK

Sociocultural Influences and HIV/AIDS among Latinos-Sarah Lopez

Wrap Up-Sarah Lopez, Nicole Scott

AGENDA-DAY 2

Check In/Review of Day 1-Jo Lewis

Exploring Personal and Cultural Values-Arlene Noriega

Microagressions and Cultural Competence: A Discussion-Jo Lewis

BREAK

Sexual Orientation and Spirituality: Paths towards Integration-Sarah Lopez

LUNCH

Presentation of the Triad Model-Malcolm Anderson

Closing: Integration of the Self, the Other, and the Work-Jo Lewis

THANK YOU FOR ATTENDING!

Cultural Diversity Institute for April 23-24 (Thurs and Friday)

1. Introductions and Updates on our lives.
2. Nicole discussed the space issues at Hopewell
3. Edit our bios
4. Discuss the list of affirming places of worship to put in handouts; Nicole will get this handout to us
5. Content
    a. Review content of previous trainings
    b. Worked on Agenda
    c. Agenda for Thursday April 23rd
        i. 9-9:15 Registration
        ii. 9:15-9:30 Welcome-Paul Plate
            1. Overview of CDI and Expectations-Sarah Lopez
        iii. 9:30-10:30 Color Exercise (2 colors: aqua, orange, lime green) Mollye and Jo
            1. Experience with addiction – yes or no
            2. Class-growing up poor vs growing up middle or upper
            3. Race- People of Color vs People considering
            4. Age: under 40 vs over 40
            5. Generation: child and adult
            6. Language- Esl or PES
            7. Gender/Gender Identity: M, F, or other
            8. Sexual Orientation and behavioral advocates: Homosexual or homosexual
            9. Ableism: Physically challenged and temporarily well bodied
            10. Religion: Christian and non-Christian
            11. Non represented group
        iv. 10:30-10:45 BREAK
        v. 10:45-12:00 The Human Face of HIV-Conversations with Helping Professionals – Arlene (Discussion 40 minutes and last 30 minutes to report out and discuss) 6 groups
            1. In small group: what is your felt need to provide this kind of service to HIV?
            2. How did you become involved?
            3. What is the most challenging experience?
            4. What is the most rewarding experience?
            5. *What would be most helpful to take from this workshop? Each group leader posts their list on wall.
        vi. 12:00-12:45 LUNCH
        vii. 12:45-1:30 Oppression and Privilege – Malcolm

viii. 1:30-2:15 Internalized Oppression & Addiction – Mollye
ix. 2:15-2:30 BREAK
x. 2:30-3:30 Sociocultural Influences and HIV/AIDS among Latinos - Sarah
xi. 3:30-4:00 Wrap up-Sarah and Nicole does the Pitch

d. Agenda for Friday April 24th
i. 9:00-9:30 Check in/Review and Follow-up from Previous Day-Jo
ii. 9:30 – 10:00 Exploring Personal and Cultural Values- how it impacts the work-Arlene
iii. 10:00-10:45 Microaggessions and cultural competence: a Discussion-Jo
iv. 10:45-11:00 BREAK
v. 11:00-12:00 Sexual Orientation and Sprituality: Paths Toward Integration-Sarah
vi. 12:00-12:45 LUNCH
vii. 12:45-2:00 Presentation of Triad Model-Malcolm
viii. 2:00-3:00 Closing: Integration of the Self, the Other, and the Work-Jo

THE END OR IS IT THE BEGINNING

The Positive Impact 2009 Education & Training Program Presents:
The 2009 Cultural Diversity Institute (CDI)
Cultivating Cultural Competence: Engaging Multiple Identities, Challenging Oppression, Creating Effective Responses
Thursday, April 23 2009 9a-4p and Friday, April 24 2009 9am-3pm

AGENDA-DAY 1

9-9:15 **Sign-In/Registration** (*Please turn off all cell phones*)

9:15-9:30 **Welcome**-Paul Plate; Executive Director-Positive Impact

↳ **Overview of CDI & Expectations**-Sarah Lopez

Color Exercise-Mollye Daughtry 9:30-10:30

BREAK 10:30-10:45

The Human Face of HIV:Conversations with Helping Professionals-Arlene Noriega 10:45-12Noon

LUNCH 12:00-12:45

Oppression and Privilege-Malcolm Anderson 12:45-1:30

Internalized Oppression and Addiction-Mollye Daughtry and Jo Lewis 1:30-2:15

BREAK 2:15-2:30

Sociocultural Influences and HIV/AIDS among Latinos-Sarah Lopez 2:30-3:30

Wrap Up-Sarah Lopez, Nicole Scott 3:30-4:00

AGENDA-DAY 2

Check In/Review of Day 1-Jo Lewis 9-9:30

Exploring Personal and Cultural Values-Arlene Noriega 9:30-10am

11am-11:30 **Microagressions and Cultural Competence: A Discussion**-Jo Lewis ~~10:00~~ 10:45

BREAK 10:45-11am

11:30-12:30 **Sexual Orientation and Spirituality: Paths towards Integration**-Sarah Lopez 11am-12-

LUNCH ~~12-12:45~~ 12:30-1:00

Presentation of the Triad Model-Malcolm Anderson ~~12:45-2~~ 1-2:15-ish

Closing: Integration of the Self, the Other, and the Work-Jo Lewis ~~2-3~~ 2:15-Close

THANK YOU FOR ATTENDING!

4 - 4:15

4:15 - 4:30

4:30 - 10:30

10:30 - 10:45

12:00 - 12:45

12:45 - 1:30

2:15 - 2:30

2:30 - 3:00

3 : 30 - 4 : 00

4 - 4:30

4:30 - 10:00

10:45 - 11am

11am - 12-

12:30 - 1:30

11:30 - 12:30

CLINICAL ISSSUES IN THE TREATMENT OF AFRICAN-AMERICANS

Vanessa McAdams-Mahmoud, LCSW

AGENDA

March 24 , 1994

I. Comparison of cultures (axiology)

II. Subcultural survival styles

III. Residuals of Enslavement

IV. Double-binds and the therapist's power

V. Break

VI. Genograms

VII. Lunch

VIII.Clinical application of theory

IX. Discussion and case studies

Midtown Psychotherapy Associates
1518 Monroe Drive
Atlanta, GA 30324
Phone: (404) 876-6595

SUGGESTED READING:

Ethnicity and Family Therapy , McGoldrick
The Destruction of Black Civilization, Williams
Black Families in Therapy, Boyd-Franklin
Understanding Race, Ethnicity and Power, Pinderhughes
Chemical Dependency and the African-American, Bell
African-Americans in Treatment, Richardson

UNIVERSAL CULTURAL VALUE ORIENTATION

1) Activity
2) Individual's relationship with others
3) Time
4) Individual's Relationship with Nature
5) Philosophy re the nature of human beings

AFRICAN-AMERICAN ETHNIC IDENTITY IS INFLUENCED BY FOUR MAIN SOURCES:

1) Residuals of African culture
2) Identification with mainstream American values (Euro-centric)
3) Victim system--a product of racism, poverty and oppression (Enslavement values)
4) Healthy integration of values with personality

EURO-AMERICAN	WEST AFRICAN	ENSLAVEMENT
INDIVIDUALISM	AFFILIATION	COOPERATION
OWNERSHIP	COLLECTIVISM	SURVIVAL BONDING
AUTONOMY	OBEDIENCE TO AUTHORITY	TOKEN OBEDIENCE
INDEPENDENCE	SHARING	SURVIVAL
MASTERY OF THE ENVIRONMENT	SPIRITUAL TRANSCENDENCE	COPING
FUTURE	PAST	PRESENT
YOUTH	ELDERS	YOUNG ADULTS
PROGRESS	TRADITION	SAFETY
ACHIEVEMENT	STABILITY	FREEDOM
POWER	SPIRITUALITY	MATERIALISM
PERFECTION	NATURAL ORDER	IMPROVISATION
PLANNING	SPONTANEITY	DEFENSIVE
PATRIARCHAL	MATRIARCHAL	ROLE DIFFUSION

HEALTHY AFRICAN-AMERICAN IDENTITY:

> A CONSCIOUS AWARENESS THAT AMERICAN SOCIETY IS HOSTILE TO ONE'S EXISTENCE

> A REASONABLE AWARENESS OF RACISM, SEXISM,CAPITALISM, MATERIALISM, AND HAS DEVELOPED A PHILOSOPHY OF COPING WITH THESE WHEN ENCOUNTERED

> ABILITIES TO RELATE WELL TO SUPERORDINATES AND SUBORDINATES AND IN INTIMATE RELATIONSHIPS

> A NEED TO BE INVOLVED IN THE SHAPING AND CONTROLLING OF ONE'S OWN DESTINY

> AN ABILITY FOR SELF-CONFRONTATION THAT IS GROWTH PRODUCING

> NOT BEING PATHOLOGICALLY STEEPED IN AN IDENTITY OF AN ALIEN CULTURE WITH CONCOMITANT HATRED AND REJECTION OF ONE'S OWN

> AN ABILITY TO PERCEIVE AND BE SENSITIVE TO THE HUMANITY OF OTHER OPPRESSED PEOPLE

> A DESIRE FOR A PERSONAL SENSE OF INNER PEACE AND WHOLENESS AND SOME REASONABLE SUCCESS IN ACHIEVING THIS.

UNCONSCIOUS RESIDUALS OF ENSLAVEMENT WITHIN AFRICAN-AMERICAN FAMILIES

1. Dehumanization of Africans and African culture
2. Idealization of Europeans
3. Idenitification with the Oppressor
4. Forced ignorance and distortion of history and reality
5. Fear of authority, enforced by violence
6. Secrecy regarding "in-group" information
7. Covert and Overt Rage
8. Religion as Propaganda for Oppression
9. Color Caste
10. Cultural Shame
11. Learned helplessness
12. Forced breeding
13. Alcohol (drugs) as an escape from oppression
14. Dissociation and denial as common defenses against trauma
15. Fear of authority, enforced by violence
16. Idiosyncratic language/Therapeutic Metaphor in Song
17. Religious worship as revolution

AFRICAN-AMERICAN CULTURAL SUBGROUPS

(adapted from Peter Ball)

TRADITIONAL STYLE

Individuals raised in families who are traditional African-American have the strongest blend of unconscious Africanisms (habits, mannerisms and dialect). Most of their important relationships are within the African-American community, and contact with other cultures usually would take place at work. Because of their tendency to be culturally immersed in their own culture, cultural identity is not usually an issue, and if questions are asked about discomfort in this area, it will be denied. However, this group is often uncomfortable in mixed settings outside of work and will avoid this as much as possible. Often the major social institution for this group is the church, and people in this group will often utilize the church as a source of status, self esteem, and emotional/spiritual comfort.

ACCULTURATED STYLE

Acculturated individuals have made both conscious and unconscious decisions to reject the general attitudes, behaviors, customs, rituals and stereotypes associated with his/her cultural background in order to assimilate into the dominant culture. Very often the acculturated person has overtly and covertly rejected his/her culture as inferior to the dominant culture. Associations with persons of his/her culture are unpleasant and uncomfortable for the acculturated person. His/her goal is to escape the oppression the stereotypes, the pain of being a minority group member. To be constantly confronted with the realities of minority group status is most distasteful and painful for this group.

BICULTURAL STYLE

The individuals who manifest this style of interaction is generally the easiest to communicate with in a cross-cultural context. The bi-cultural person has a good sense of his/her own cultural identity and yet is comfortable in a cross-cultural context. The bi-cultural person is comfortable operating outside of his/her own cultural frame of reference. The bi-cultural person is not rejecting of other cultures, nor his/her own. Very often this person seeks out diversity and is stimulated by it. Problems of this group, however, include the possibility of being seen as acculturated or rejecting of his/her group. Also the bi-cultural person may experience "cultural schizophrenia"--a feeling of being caught between two worlds.

AFROCENTRIC STYLE

These people exhibit an interpersonal style that has rejected the majority culture and much of what it stands for. The terms, militant, ethnocentric, or radical might often be applied to persons who exhibit this style. In African-Americans, this style is often accompanied by a pursuit and appreciation of African culture and history. Confounding cross-cultural

communications with this person is his/her ability to legitimately articulate issues relating to their own oppression by society. The therapist must be able to separate the client's responsibility for his/her own behavior from the societal oppression which the client may see as the reason for most of his/her problems. Afrocentricity, however, has been associated with the leading African-American intelligentsia, and is responsible for the theoretical background for social change in teh African-American community. It is often cohesive, ego-strengthening, source of identification with positive African values. These often serve to support healthy self-esteem and self-love. This is often an antidote to residuals of enslavement culture which may persist in certain families

SURVIVALIST STYLE

This style is associated with families who have had a lot of experience within street culture, or grew up in an environment where these values predominate. The primary ethic of a survivalist is power through force or violence, survival of the fittest, materialism versus spirituality, and the ability to be cold and ruthless when one must. There is within this style a strong "no talk, no trust" rule. This style tends to be male dominant, and there may be a good deal of identification with the aggressor in interpersonal dynamics. People who interact within this style are often tested,taunted and stone-walled within this group. It is important to recognize when one is intimidated without becoming authoritarian in defense.

All substyles have two application modes : Adaptive and Maladaptive

Adaptive: ***this mode is characteristic of a person who uses the tools characteristic to his/her substyles in a way that is growth-producing. This person achieves a healthy integration of personality with culture . Although they experience cultural shame, they are able to achieve a level of understanding that allows them to heal and to move beyond the emotional obstacles of that shaming. They are able to take responsibility for their own actions in relationships and move actively to understand how they may improve those relationships.***

Maladaptive: ***this mode is characteristic of those persons who use the tools characteristic to his/her substyle but have difficulty using those tools to develop self and to grow. They have significant difficulty integrating personality with culture, and may still experience cultural shame which is repressed and sometimes projected onto others. They are significantly impaired by these difficulties, which effectively limit the healthy integration of personality with culture. They may seem to have a cultural identity disorder, of a persistent and intractable nature.***

INDICATORS OF PERSONAL EMPOWERMENT AND RECOVERY FROM RESIDUALS OF ENSLAVEMENT

1. Recognition of and appreciation for Africans and African culture as practiced and interpreted by Africans

2. Recognition of strengths and weaknesses of Europeans and European culture

3. Recognition and owning of one's anger and what led to it; to seek neither to oppress or allow oppression

4. Recognition of the history of African-Americans in this country and one's place in that history

5. Respect of legitimate authority, to be able to relate to people with authority appropriately (to agree or disagree as needed)

6. Practice telling one's truth in all appropriate settings

7. To understand the roots of one's anger and shame due to racist abuse and shaming

8. To choose to worship in a way that enhances one's functioning in family life and in the greater society

9,10 To appreciate the diversity of African-Americans and accept the blending of African, Native American and European cultures which contribute to what an African-American is; to see the beauty in all shades of skin, hair texture and dialect.

11. To recognize one's strengths and limits; to exercise power when necessary and in appropriate ways

12. Acceptance of socio-cultural realities as a way to facilitate decision making, and define the boundaries of personal responsibility

13. Responsible and effective parenting; development of intimate, committed relationships; mutual respect between sexes

14. Ceasing the use of mind-altering substances as avenues of escape from oppression

15. Acknowledging, discussing and grieving traumatic experiences with trusted

PHYSICAL MALTREATMENT

BEATINGS (box on the ears, body blows with hand, elbows, arms, rapping the hands)
ELECTRICITY
FLESH WOUNDS (with bare hands,fingernails, weapons i.e. knives, knitting needles, scissors)
FRACTURES (from being hurled across the room, pushed, doors slammed on them, hit, kicked)
BURNS (from lighted cigarettes, burning matches, hot water, cigarette lighters, etc.)
CHOKING (with bare hands, electrical cord, car windows, etc.)
CONTUSIONS
HAIRPULLING
HANGING
TWISTING BODY PARTS
BLOODLETTING
EXPOSURE TO COLD
IMMERSION
SLEEP DEPRIVATION
COMPULSORY LABOR
EATING
INJECTIONS
NEEDLES
PILLS
ALCOHOL
HEAD RAMMING
LETTING THINGS DROP ON THE CHILD
TORTURE CHAMBER

CHARACTERISTICS OF SURVIVORS

1. EXTREME DESTRUCTIVENESS TOWARD SELF, IMAGINED ENEMIES, OR LESS POWERFUL OTHERS

2. DISCHARGE OF HATRED IS DISPLACED ONTO OTHERS

3. ABUSE CONDUCTED IN AN ATMOSTPHERE OF HUMILIATION,SHAME

4. HEALTHY REACTION OF RAGE SHARPLY SUPPRESSED BY AUTHORITARIAN PARENTS

5. NO OTHER ADULT IN WHOM SURVIVORS FEEL THEY COULD CONFIDE

6. STRONG NEED TO COMMUNICATE SUFFERING TO THE WORLD

7. UNCONSCIOUS ENACTMENT

8. SOCIETY REACTS NEGATIVELY TO THE ENACTMENT, AT THE END OF THIS CYCLE

9. REPETITION COMPULSION RESULTS IN UNDIVIDED PUBLIC ATTENTION FOR A BRIEF PERIOD

Culturally effective therapeutic abilities

The ability to reflect back to the client a realistic but hopeful image of themselves

The ability to understand the historical relevance of the conflict in question to the family and to also understand the historical context of the relationship between himself/herself and the family

The ability to encourage famiies to use information gained in their participation in family therapy, for liberation and creativity, and not just for adaptation to the greater society

The ability to identify clients with cultural identity disorders, or color caste conflicts, and to relate to them in a way that helps to enhance their internalized picture of themselves

The ability to not deny historical patterns of oppression when encountered by a client, but to help them deal with the pain and emotional scarring that such oppression has caused them, in a liberating and empowering way

The ability to be culturally and/or linguistically fluent in another culture outside their own in a respectful, egalitarian, way

The ability to recognize the levels of acculturation in bicultural biracial and bilingual students and the shortcomings of each level as well as the positive nature of each

The ability to be aware of one's own cultural heritage and their level of comfort with it as well as one's own internalized picture of self, one's prejudices, cultural chauvinism and personal power

POSITIVE IMPACT, INC.

Cultural Diversity Institute

February 21st and February 22nd, 2008

CULTIVATING CULTURAL COMPETENCE: Engaging Multiple Identities, Challenging Oppression, Creating Effective Responses

AGENDA – DAY 1

9:00 – 9:15 am	***Welcome*** - Paul Plate ***Overview of CDI*** – Sarah Lopez
9:15 – 9:30 am	***"Up/Down Exercise"*** - Craig Washington
9:30 – 10:30am	***Cultural Identities: Who are We?*** - Jo Lewis
10:30 – 10:45 am	***BREAK***
10:45 – 12:15pm	***Panel: The Human Face of HIV – Perspectives from Helping Professionals*** *Moderator:* Craig Washington
12:15 – 1:15 pm	*LUNCH*
1:15 – 2:15 p.m.	***Oppression & Privilege*** – Vanessa Jackson
2:15 – 2:30 p.m.	***BREAK***
2:30 – 3:30 p.m.	***Sociocultural Influences and HIV/AIDS among Latinos*** Sarah Lopez and Manuel SMejorada
3:30 – 4:30pm	***Internalized Oppression& Addictions*** - Mollye Daughtry
4:30 – 5:00 p.m.	***Closing Circle: Integration of Day 1*** - Sarah Lopez

POSITIVE IMPACT, INC.

Cultural Diversity Institute

February 21st and February 22nd, 2008

CULTIVATING CULTURAL COMPETENCE: Engaging Multiple Identities, Challenging Oppression, Creating Effective Responses

AGENDA – DAY 2

9:00 – 9:30 a.m.	***Check-in/Review & Follow-up from Previous Day*** - Sarah Lopez
9:30 – 9:50 a.m.	***Exploring Personal & Cultural Values***
9:50 – 10:00am	***Application of Cultural Competence*** – Manuel Mejorada
1000 – 10:15 a.m.	*BREAK*
10:15 – 11:45 a.m.	***Panel: Sexual Orientation and Spirituality: Paths Toward Integration*** Facilitator: Sarah Lopez
11:45 – 12:30 p.m.	
12:30 – 3:00 p.m.	***Presentation of Triad Model*** – Malcolm Anderson
	Part I: Understanding Who We Are and How We Are Responding to Persons with HIV/AIDS
	Part 2: Skills Building for Human Service Providers
3:00 – 3:15 pm.	BREAK
3:15 - 4:00 p.m.	***Small Group Discussion on Cultural Values***
4:00 – 4:30 p.m.	***Wrap-up/Feedback/Closing Comments*** – Sarah Lopez

Understanding Worldviews

Oppression and the importance of self awareness and cultural histories

4/23/2009 1

Worldviews

- Each individual/group develops a distinct set of rules by which to view their world. This perception is then passed down in variation to other members of the group via socialization in the form of histories, story-telling, music, arts, rituals and other "customary ways of doing things."

4/23/2009 2

Worldviews

- Cultural worldviews can be broadly defined to describe how a culture perceives its relationship/approach to the world (nature, institutions, other people, things, etc.)
- An individual who has grown up in a particular culture group develops his/her personal worldviews largely based on their cultural background and personal experiences.

4/23/2009 3

Worldviews

Sue and Sue (1999)

- "Not only are worldviews composed of our attitudes, values, opinions and concepts, but they also may affect how we think, make decisions, behave and define event outcomes."
- Culture in this light informs behaviors and, therefore, affects outcomes and perceptions that influence future behaviors which later become adaptations that may become traits and or predispositions of behaviors (genetic transmission)

4/23/2009 4

Worldview Differences

"For clients, culture determines WHAT they see as the problem, HOW they express it, WHOM they seek for help, the TREATMENT strategies they prefer and WHAT they regard as helpful" (McGoldrick, 1983).

4/23/2009 5

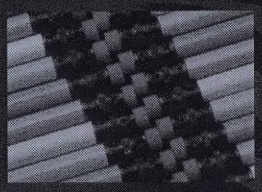
Ethnocentric Monoculturalism

- Is based on a belief system of superiority (explicit or implicit) that one is more advanced and therefore is more normal, better, correct than the next human being. Inherent is the belief that because one has been given certain benefits in a society (i.e., larger in number, power, control, vital resources) one, therefore, can impose standards of acceptance and normality. From this emerges the imposition of such unearned power to become the foundation of oppression.

4/23/2009 6

Cultural Encapsulation

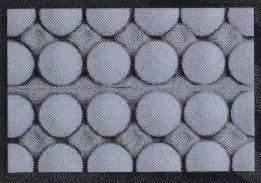
- A defense that is initiated when differences become so overwhelming that they dominate *the way* people are assessed, diagnosed and treated. It renders the therapist unable to see the commonalities between all people.



4/23/2009 7

Culture Blindness

- A therapist defense that is initiated when differences become so overwhelming that the therapist simplifies the information by minimizing cultural difference and omitting the unique cultural circumstances of the client and the client's group to remain "impartial and fair"



4/23/2009 8

Dimensions Oppression

- Cultural encapsulation and cultural blindness represent the cornerstones of oppressive therapeutic exchange and can lead to inauthentic styles of relating to patients. This inauthenticity may lead to overt levels of mistrust and fear in the patient which tend to polarize the dyad in an oppressor/victim dichotomy

4/23/2009 9

Power

- Power is a moderator of ethno/cultural group membership, especially in a pluralistic society. It is based on the perceptions of the dominant group

4/23/2009 10

Worldview and Cultural Attribution

- Often times one's worldview can form from the the various cultural attributions applied to situations.
- The variants in these situations are the perceptions of the individual on the environment and themselves as well as how the environment perceives them in the situation.

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Locus of Control

(Rotter, 1966)

- A measurement of a generalized personality trait that addresses the reinforcers that predict the success or failure attributed to a task being accomplished
- This attribution has a cultural interpretation that is based on the culturally based experiences and values of the individual and their membership group

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Locus of Control

- Internal locus of Control (IC)
  - The belief that success and failures are attributed to internal qualities of the individual
    - Skills, effort, talent, hard-work
- External Locus of Control (EC)
  - The belief that successes and failures are attributed to factors that are external to the individual
    - Luck, fate, chance

4/23/2009 13

Locus of Responsibility

(Jones, Kanouse, Kelley, Nisbett, Valins & Weiner, 1972)

- A measurement of the degree of responsibility or blame placed on an individual or system for shaping one's behavior.
- To what does one blame the actions, reactions, motivations or orientations they maintain when things go wrong or in an unfavorable way

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Locus of Responsibility

- Person Centered (IR)
  - Generally blames self and own actions or lack of actions for why things are the way things are or do not go in a desirable way
- Situation Centered (ER)
  - Generally blames others or larger social systems (e.g. political groups, members of larger social groups and oppressive groups in power) for the way things are or aren't.

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Integrated Worldview Model

	Internal (Personal)	External (Situational)
Internal	*IC-IR*	*IC-ER*
External	*EC-IR*	*EC-ER*

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Oppression

- "We all have the basic creative inner center of direction, but this can be smothered by oppression and hopelessness. The authentic human self must have power to exert some effect on events in the world in order to be truly and fully human. The power to influence is a uniquely evolved quality of being human. . ."
- "We all have the basic creative inner center of direction, but this can be smothered by oppression and hopelessness."

Rev. Carl J. Westman, 1911 - 2004

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Externalized Cultural Oppression

- Involves beliefs and value systems that support the superiority of the dominant cultural
- It usually involves feelings of devaluation or the perception of eternal hopelessness in which individuals who are assigned (self or other) to particular groups are prohibited to thrive or not bestowed grace for their existence in an unfair environment.
- The most important aspect of this form of oppression involves the majority ethic of privilege that perpetuates the polarities of the two groups and blames the smaller oppressed group for their own difficulties rather than acknowledging the systemic nature of the oppression.

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Privilege

- Defined as a package of benefits, granted to people in our society who have qualities or resources that allow certain "free passes" that are not easily available to other people due to restrictions in the society.

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An example

"White Privilege: Unpacking the Invisible Knapsack"
Peggy McIntosh

"I have come to see White privilege as an invisible package of unearned assets that I can count on cashing in each day, but about which I was "meant" to remain oblivious."

4/23/2009 20

Internalized Oppression

- Occurs when individuals or institutions incorporate into their self-identity either consciously or unconsciously the negative values and biases placed on them by the majority culture.
- Internalized oppression may include feelings of self-hatred or participation in acts that are either self-destructive or that devalue another member of their minority group

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Exploring Personal and Cultural Values:
A workshop for Positive Impact, Inc.
Presenter: Malcolm E. Anderson, Ph.D.

CULTURAL DIVERSITY INSTITUTE

INTRODUCTIONS

Who's who???

Draw a Home

- Find a partner
- Use one (1) pen or pencil
- Use one (1) sheet of paper
- Together draw a picture of a home
- Do not talk about it
- Try not to direct each other (verbally or non-verbally)
- When you are finished look up and observe others quietly

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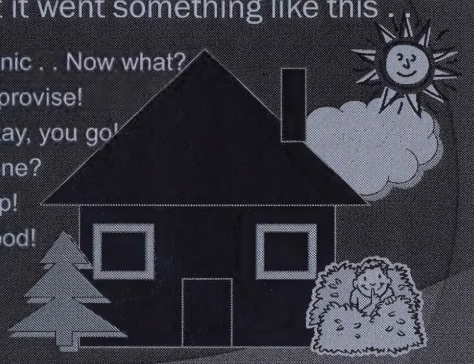
I bet it went something like this . .

- Panic . . Now what?
- Improvise!
- Okay, you go!
- Done?
- Yup!
- Good!



Process: What did you learn?

- What was the process of the exercise like?
- What did you think about before starting, during and after the drawing?
- How did you do it?
- Who started, who finished the drawing
- Was it more difficult in the beginning, the middle or the end?
- How much of who you are is in the drawing?
- What does that mean?

What's in the mix?

CULTURAL WORLDVIEWS AND PERSONAL VALUES

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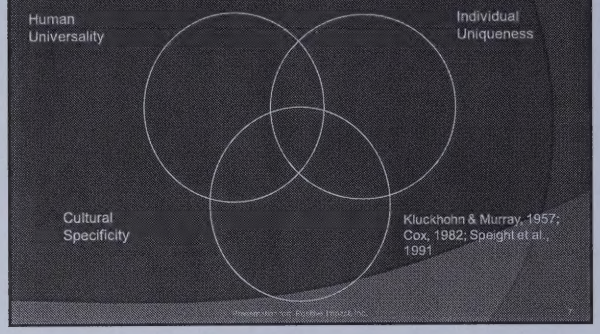
WORLDVIEW ORIENTATION



Kluckhohn & Murray, 1957; Cox, 1982; Speight et al., 1991

Worldviews

- Each group develops a distinct set of rules by which to view their world. This perception is then passed down in variation to other members of the group via socialization in the form of histories, story-telling, music, arts, rituals and other "customary ways of doing things."

Worldviews

- Cultural worldviews can be broadly defined to describe how a culture perceives its relationship/approach to the world (nature, institutions, other people, things, etc.)
- An individual who has grown up in a particular culture group develops his/her personal worldviews largely based on their cultural background and personal experiences.

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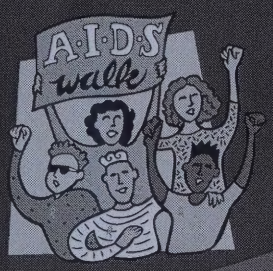
Worldviews

Sue and Sue (1999)

- "Not only are worldviews composed of our attitudes, values, opinions and concepts, but they also may affect how we think, make decisions, behave and define event outcomes."
- Culture in this light informs behaviors and, therefore, affects outcomes and perceptions that influence future behaviors. These behaviors later become adapted and form into traits and/or predispositions of behaviors that can be passed down through generations (genetically).

How do our worldviews and personal values effect our work with persons with HIV/AIDS?



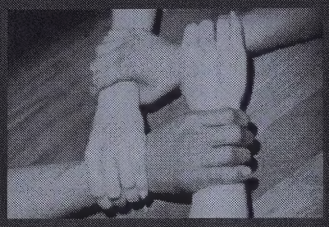
UNDERSTANDING CROSS-CULTURAL CONFLICTS IN TREATMENT:

Ways to avoid therapeutic impasse and increase treatment viability with persons with HIV/AIDS

Presented by: Malcolm E. Anderson, Ph.D.

How do we react/respond to persons with HIV/AIDS?

Understanding who we are is a good start!



THE DOOR STEPS TO IMPASSE

THERAPIST'S DEFENSES

How do therapists cope anxiety caused by difference?

- Ridley (1995) noted significant therapist defenses in response to counter-transference issues raised by culturally "different" or "similar" clients.
- Each defense represents an effort on the part of the therapist to cope with the anxiety and complexity involved in treating someone who is culturally different.

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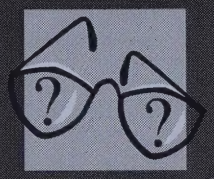
Therapist's Defenses Ridley (1995)

- Culture blindness (overly absolutist)
- Culture consciousness (overly relativist)
- Cultural transference avoidance (non-empathic)
- Blind allegiance (too much empathy)
- Identification with the oppressor (blaming)



Cultural Blindness

- A defense that is initiated when differences become so overwhelming therapist's depend solely on commonalities between people and thus minimize cultural differences and unique cultural circumstances from case to case in an effort to remain "impartial and fair"

Cultural Encapsulation

- A defense that is initiated when differences become so overwhelming that they dominate *the way* therapist's see their patients. It renders one unable to see the commonalities between all people.

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Impasse is . . . .

- A point of "stuckness", immobility, impotence, ineptitude, and/or circular movement with no advancement.
- Impasse sucks the life out of good therapy by rendering the therapist and the patient unable to reach their goals
- Impasse also negatively affects rapport and sabotages trust in the therapeutic relationship.

Impasse impedes decision-making

- Impasses are often reflected in miscommunication
- Impasses are experienced in power struggles
- Impasses are present in during periods of mis-information
- Impasses can be brought about via sexual attraction
- Impasses are often witnessed when there is cultural difference

Common Impasses

- Under bounded – the therapist is too far outside the client system to have in impact. The client or problem remains unchanged and relentlessly remains as the transactional linkage and focus (paucity of knowledge).
- Over bounded – the therapist finds themselves stuck in a role too inside the client system. This repetitious involvement creates a rigid, role defined position that allows limited maneuvering (counter-transference).

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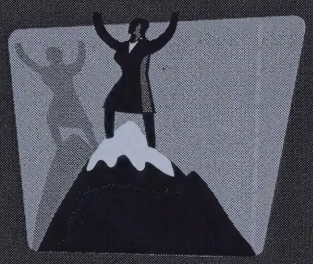

Interpersonal Struggles

Impasses are often unconscious and represent at times wishes or fantasies we have about our patients, how we envision therapy to be proceeding, or how we think the patient is benefiting from the treatment.

22

The impasse dilemma

- When confronted with an impasse the aware therapist generally works hard to contemplate action
- Often this action is though well thought out, presents a risk to the standard of care or to the moral, or ethical judgment of the therapist
- In turn, this action may present potential harm to the patient given it is exploratory and is triggered by the impasse

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Failure to act on the impasse

- May truncate the therapist's perceived spontaneity
- Reduce their creativity
- Call intuition into question
- Render the therapist feeling helpless
- Stunt progress and impede the patient's recovery.

(Pope, K.S., Sonne, J., and Holroyd, J. (1993)

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Impasse causes conflict

- Because we often lack complete empathy and are prone to clinical guess work at times, we are often in conflict with patients who present as different from us.
- Cultural difference presents a greater opportunity for impasse as misunderstanding and misinterpretation are more likely.
- Added to the presence of cultural difference is the complexity of diagnostic information from which we often generalize conceptualizations treatment ideas to reduce the threat of difference.

So what do we do?

- Although there remains no sure, tested way to detect or resolve impasse, many therapists acknowledge that it is a process culminating over a series of sessions.

(Carter, 2004; Elkind, 1992; Omer, 2000)

How serious is this matter, really ?

Options to consider

- Consultation
- Literature review
- Introspection
- Supervision
- Begin or resume personal therapy

- Acknowledging short-comings is difficult
- I am left to integrate new material into existing knowledge
- I may have to face my level(s) of incompetence
- It may lead to other issues about me that I am not ready to face

Problems with these options?

Uh-Oh!

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Conflict jeopardizes treatment

- Once in conflict the therapeutic dyad becomes stymied and stagnant.
- Therapeutic progress is inhibited
- The therapist's competence becomes a focus of each member of the dyad
- Defenses begin to dominate the relationship and inhibit effective communication
- Alienation and isolation become apparent to both the therapist and the patient

A word about ethical relativism

- Since patients can differ widely in their moral practices given their different cultural experiences, it would seem practical for therapists to adopt the use of a relativist perspective when presented with ethical dilemmas and impasse.
- There are short-comings:
  - Homicide/suicide
  - Romantic or sexual attraction
  - Abuse and harm

The Interpersonal Grid

Pedersen (1985, 94)

- Type I relationships:
  - Two people have similar behaviors and similar expectations. High level of accuracy in both people's interpretations of one another's behavior.
- Type II relationships:
  - Two people have different behaviors but share the same expectations. High accuracy in intention but low level of accuracy because differences in behaviors are interpreted differently (cross-cultural conflict)

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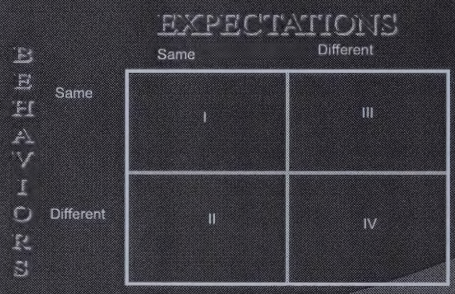
Interpersonal Grid continued

- Type III relationships
  - Two people have the same behaviors but differ greatly in their expectations. There is actually a low level of agreement between the two people as to the interpretation of the behavior.
- Type IV relationships
  - Two people have different behaviors and different expectations. They do not agree in their interpretation or expectation of each other. Generally results in a hostile exchange due to the inaccuracy and misinterpretation

Inter-Personal Grid Pedersen (1985, 94)



A training module for mediating cross-cultural conflict

THE TRIAD MODEL

Education & Training Program

2010-2011

Cultural Diversity Institute (CDI)

Cultivating Cultural Competence:

Engaging Multiple Identities, Challenging Oppression, Creating

May 20, 2010
9:30am– 4pm
&
May 21, 2010
9:30 am—4:00 pm

CELEBRATING 16 YEARS OF SERIVCE
POSITIVE IMPACT
PROVIDING MENTAL HEALTH & PREVENTION SERVICES FOR PEOPLE AFFECTED BY HIV
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The 2010 Cultural Diversity Institute [CDI]

Cultivating Cultural Competence: Engaging Multiple Identities, Challenging Oppression, Creating Effective Responses

About the Workshop

Understanding the role of oppression and its connection to HIV is more important than ever in our present sociopolitical climate. It is vital to explore and address the impact of cultural oppression and corresponding coping strategies on those affected by HIV, including mental health caregivers.

This training will explore the prevalence of cultural and individual oppression among diverse HIV populations and challenge providers to improve their assessment and intervention skills. The training will also enhance participant's understanding of the impact of biases in their own lives and help them identify areas for further personal and professional growth.

Positive Impact

"Providing Culturally Competent Mental Health & Prevention Service for people affected by HIV"

- Mental Health Counseling
- Psychiatric Assessment
- Targeted HIV Prevention Programs
- Latino Outreach
- Homeless Outreach
- Substance Abuse Treatment Center
- HIV Testing Center
- Clinical Internship Program
- Education & Training Program
- Community Advisory Boar
- Clinical/Non Clinical Volunteer Program

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The CDI Faculty

Malcolm E. Anderson, Ph.D

Dr. Anderson is a Clinical Psychologist in private practice who has co-facilitated pro-bono HIV/AIDS workshops for Positive Impact Inc. for many years. Dr. Anderson has served as a member of the P.I. Board and assisted with coordinating clinical services. He has been an Associate Professor of Clinical Psychology at Argosy University for 10 years.

J. Alan Graham, Ph.D.

Dr. Graham is a clinical psychologist in private practice. During graduate school he worked in various addiction treatment centers including Talbott-Marsh Recovery Campus for impaired professionals. Additionally, his doctoral exams and dissertation research focused on Addiction Treatment. He has been a volunteer with Positive Impact for over 15 years.

Jo Lewis, Psy.D

Dr. Lewis is a Clinical Psychologist in private practice and the founder of The Center for Cooperative Change in Decatur. A seasoned trainer/consultant, Dr. Lewis is a teaching member of the International Transactional Association.

Sarah Lopez, Ph.D

Dr. Lopez is a Clinical Psychologist in private practice and has co-facilitated a pro-bono HIV/AIDS psychotherapy group for 17 years. She has been affiliated with Positive Impact in many capacities and has served as Board Chair and as its first Latino Outreach Coordinator.

Arlene Noriega, Ph.D

Dr. Noriega is a clinical Psychologist practicing in the area of cross cultural competence and health psychology for 18 years. She is currently in private practice with Stonewall Psychological Associates and consults on issues of multicultural competence. She has been a trainer with the HIV Office for Psychologist Education with APA.

Continuing Education

10 CEU hours have been approved by the Licensed Professional Counselors' Association of Georgia and the Society for Clinical Social Workers

Education & Training Program

To learn more about Positive Impact, The Cultural Diversity Institute, Education & Training, or Volunteer Opportunities, please contact:

Dedra Cochran,
Volunteer and Training Director
404-589-9040 ext.104 or
Dedra.cochran@positiveimpact-atl.org.

Special Thanks

Guy Pujol
Taisha Rose
Dr. Eli Budd
Patrick Kelly
John Adamski
Marie Jamison
William Francis
Bill Hufschmidt
Claudia Becerra
Terence McPhaul
Kenneth D. Gantt
Yotin Srivanjarean
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- Arlene Noriega drnor@bellsouth.net
Malcolm Anderson — drmalcolmtherapist@earthlink.net

Dedra Cochran

From: sol21@aol.com
Sent: Sunday, May 16, 2010 12:08 AM
To: gkaufmanjr@aol.com; newdocsc@yahoo.com; jadamski@bellsouth.net; freeangeladavis@gmail.com; Bill@JaiShantiYoga.com
Cc: Dedra Cochran
Subject: Upcoming panel
Attachments: Cultural_Diversity_Institute_Flyer.pdf

Dear Panel Members,
I am delighted by the way our panel has come together, and I'm especially grateful given the particularly short notice involved for most of you. I have attached the flyer for Positive Impact's 2-Day Cultural Diversity Institute which includes the address for St. Mark's.

Our panel, SEXUAL ORIENTATION AND SPIRITUALITY: PATHS TOWARD INTEGRATION will be on Friday from 12:30 - 2PM. Lunch will be served from 12 - 12:30, and if we can gather at noon, that would give us an opportunity to meet each other before presenting. If you can only arrive in time for the panel, please know that I am most appreciative of your arranging you schedules to do so.

In addition to myself as participating Chair, the other panel members will be:
John Adamski, Pastor of Our Lady of Lourdes Catholic Church
Angela Denise Davis, ordained minister and social justice activist
Bill Hufschmidt, Owner/Instructor: Jai Shanti Yoga and Thai Massage Therapist
Gus Kaufman, Psychologist, Activist, and representative of Congregation Bet Haverim
~~James Suber~~ Guy Rujol, AIDS Alliance for Faith and Health's Common Ground Program
Please let me know if any of you wish a different listing in the program.

My goal is to provide a helpful structure in framing the discussion without limiting the flow of spirit in the experience as a whole.

We will start with each person sharing (3-5 minutes) his/her personal odyssey in understanding the integration of sexual orientation and religious/spiritual calling.

Further questions to be explored:

1. What different issues or significant patterns have you witnessed personally or professionally in other people's journey in integrating sexual orientation and religious/spiritual calling?

2. How do you manage or help others work with the "tension of Opposites" of religion being experienced as a significant resource and support vs. a source of ongoing condemnation and oppression?

3. What guidance can you offer in working with the guilt, shame and stigma often associated with an HIV+ diagnosis that is sourced by religious/spiritual beliefs and training?

4. What do you recommend for those who yearn to be connected with spirit yet are fearful of being harmed or judged if they were to become involved with a faith community?

5. What else do you think is helpful in healing the alienation and damage caused by institutionalized homophobia, particularly on those with HIV?

Please feel free to E-mail me any questions, issues, or reflections you might want added.

I'm very excited about entering into the creative synergy that awaits us all in our coming together for this training.

Sarah

Rosalinda
Direct (4)720-7807
General (4)720-7900

The Positive Impact 2009 Education & Training Program Presents:
The 2009 Cultural Diversity Institute (CDI)

Cultivating Cultural Competence: Engaging Multiple Identities, Challenging Oppression, Creating Effective Responses

Thursday, April 23 2009 9a-4p and Friday, April 24 2009 9am-3pm

AGENDA-DAY 1

Sign-In/Registration (*Please turn off all cell phones*)

Welcome-Paul Plate; Executive Director-Positive Impact

Overview of CDI & Expectations-Sarah Lopez

Color Exercise-Mollye Daughtry

BREAK

The Human Face of HIV:Conversations with Helping Professionals-Arlene Noriega

LUNCH

Oppression and Privilege-Malcolm Anderson

Internalized Oppression and Addiction-Mollye Daughtry and Jo Lewis

BREAK

Sociocultural Influences and HIV/AIDS among Latinos-Sarah Lopez

Wrap Up-Sarah Lopez, Nicole Scott

AGENDA-DAY 2

Check In/Review of Day 1-Jo Lewis

Exploring Personal and Cultural Values-Arlene Noriega

Microagressions and Cultural Competence: A Discussion-Jo Lewis

BREAK

Sexual Orientation and Spirituality: Paths towards Integration-Sarah Lopez

LUNCH

Presentation of the Triad Model-Malcolm Anderson

Closing: Integration of the Self, the Other, and the Work-Jo Lewis

THANK YOU FOR ATTENDING!

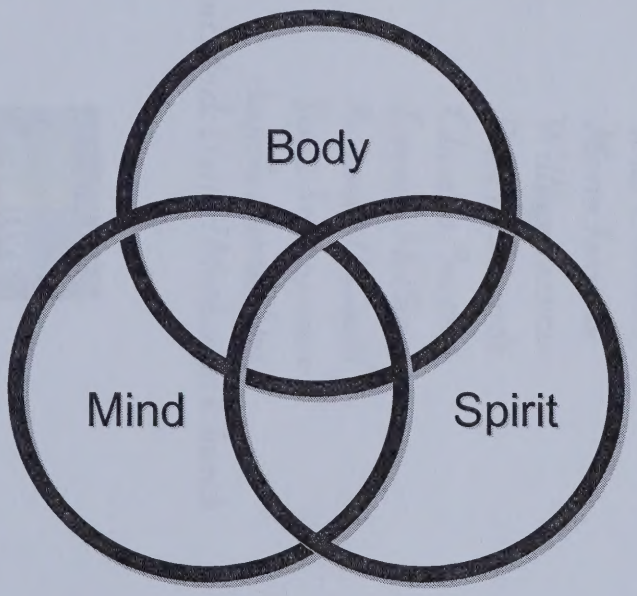
Spirituality and Living with HIV

by: Guy Pujol, D.Min.

Health means more than just physical health; and, healthy living means more than just caring for our bodies. Holistic health means taking care of our selves not only physically but also mentally and spiritually.

Body, mind, and spirit are interconnected and essentially determine who we are as human beings. Caring for our spiritual selves, therefore, is just as important as monitoring CD4+ counts and viral load. Customarily, spirituality affects our physical health as much as medications, proper nutrition, and exercise.

Spirituality is that center around which we order our lives. For each person, that object or center may differ. For theists, or people who believe in a God, gods, or an Ultimate Power, the object or center around which they order their lives will be defined or described in terms of the Holy.



For non-theists, spirituality is primarily defined by a concept or core value around which they order their lives. Such concepts or values may include love, justice, peace, mercy, compassion, kindness, or knowledge.

I define spirituality as that inner calling which motivates and challenges people to live ethically. How we live our lives may be a better indicator of our spirituality than what we claim our spirituality to be. In other words, spirituality is more than prayer, meditation, contemplation, or personal reflection. It is those things *plus* our actions. Caring for ourselves, others, and our community is how we best demonstrate our spirituality.

Similarly, our health—not only our spiritual and emotional health but also our physical health—is an indicator of our spirituality. People who are spiritually grounded generally live longer and have improved quality of life.[1] People who are spiritually centered have less stress in their daily lives (which benefits the immune system), are happier and less likely to be depressed, and tend to develop stronger social support networks; and, studies have shown that people living with HIV who have strong support systems live longer, healthier lives. Ultimately, everyone benefits from spiritual involvement.

While spirituality has measurable outcomes—such as our physical wellbeing—it is not an isolated task; rather, it is a process.

Spirituality is a personal journey; and, the therapeutic value comes in the journey itself. Each journey begins with taking the next step from where you are now. As you contemplate your next step, complete the following sentence:

Given where I am on my spiritual journey, one thing I can do this week to take that next step toward my own spiritual health is _____.

As you take action to make that statement a reality, trust that your physical health may benefit from that spiritual involvement.

[1] Tuck, Inez, et. al. "Spirituality and Psychosocial Factors in Persons Living with HIV." *Journal of Advanced Nursing*, 0309-2402, March 15, 2001, Vol. 33, No. 6, 776-783.

AIDS Alliance for Faith and Health

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www.AIDSAllianceATL.org

Positive Impact

"Providing Culturally Competent Mental Health & Prevention Service for people affected by HIV"

- Mental Health Counseling
- Psychiatric Assessment
- Targeted HIV Prevention Programs
- Latino Outreach
- Homeless Outreach
- Substance Abuse Treatment Center
- HIV Testing Center
- Clinical Internship Program
- Education & Training Program
- Community Advisory Boar
- Clinical/Non Clinical Volunteer Program

Special Thanks

Guy Pujol
Taisha Rose
Dr. Eli Budd
Patrick Kelly
John Adamski
Marie Jamison
William Francis
Bill Hufschmidt
Claudia Becerra
Terence McPhaul
Kenneth D. Gantt
Yotin Srivanjarean
Angela Denise Davis
Saint Mark United Methodist Church

Positive Impact, Inc.

139 Ralph McGill Blvd.
Suite 301
Atlanta, GA 30308
Phone: (404) 589-9040
Fax: (404) 589-1615
positiveimpact-atl.org

Education & Training Program

2010-2011

Cultural Diversity Institute (CDI)

Cultivating Cultural Competence:

Engaging Multiple Identities, Challenging Oppression, Creating

May 20, 2010
9:30am– 4pm
&
May 21, 2010
9:30 am—4:00 pm

CELEBRATING 16 YEARS OF SERIVCE
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PROVIDING MENTAL HEALTH & PREVENTION SERVICES FOR PEOPLE AFFECTED BY HIV
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The 2010 Cultural Diversity Institute [CDI]

Cultivating Cultural Competence: Engaging Multiple Identities, Challenging Oppression, Creating Effective Responses

About the Workshop

Understanding the role of oppression and its connection to HIV is more important than ever in our present sociopolitical climate. It is vital to explore and address the impact of cultural oppression and corresponding coping strategies on those affected by HIV, including mental health caregivers.

This training will explore the prevalence of cultural and individual oppression among diverse HIV populations and challenge providers to improve their assessment and intervention skills. The training will also enhance participant's understanding of the impact of biases in their own lives and help them identify areas for further personal and professional growth.

The CDI Faculty

Malcolm E. Anderson, Ph.D

Dr. Anderson is a Clinical Psychologist in private practice who has co-facilitated pro-bono HIV/AIDS workshops for Positive Impact Inc. for many years. Dr. Anderson has served as a member of the P.I. Board and assisted with coordinating clinical services. He has been an Associate Professor of Clinical Psychology at Argosy University for 10 years.

J. Alan Graham, Ph.D.

Dr. Graham is a clinical psychologist in private practice. During graduate school he worked in various addiction treatment centers including Talbott-Marsh Recovery Campus for impaired professionals. Additionally, his doctoral exams and dissertation research focused on Addiction Treatment. He has been a volunteer with Positive Impact for over 15 years.

Jo Lewis, Psy.D

Dr. Lewis is a Clinical Psychologist in private practice and the founder of The Center for Cooperative Change in Decatur. A seasoned trainer/consultant, Dr. Lewis is a teaching member of the International Transactional Association.

Sarah Lopez, Ph.D

Dr. Lopez is a Clinical Psychologist in private practice and has co-facilitated a pro-bono HIV/AIDS psychotherapy group for 17 years. She has been affiliated with Positive Impact in many capacities and has served as Board Chair and as its first Latino Outreach Coordinator.

Arlene Noriega, Ph.D

Dr. Noriega is a clinical Psychologist practicing in the area of cross cultural competence and health psychology for 18 years. She is currently in private practice with Stonewall Psychological Associates and consults on issues of multicultural competence. She has been a trainer with the HIV Office for Psychologist Education with APA.

Continuing Education

10 CEU hours have been approved by the Licensed Professional Counselors' Association of Georgia and the Society for Clinical Social Workers

Education & Training Program

To learn more about Positive Impact, The Cultural Diversity Institute, Education & Training, or Volunteer Opportunities, please contact:

Dedra Cochran,
Volunteer and Training Director
404-589-9040 ext.104 or
Dedra.cochran@positiveimpact-atl.org.

Nicole Scott

From: Craig Washington
Sent: Wednesday, February 13, 2008 8:15 AM
To: Nicole Scott
Subject: cultural diversity workshop preparation

Here are some key preparation tasks for next weeks cultural diversity workshop.

Tasks:
Assign a minimum of 5 interns and/or work study students to help set up, greet and sign folks in
Revise and make copies of Training Manual content sections
Assemble manuals (check with Mark about status of binders order) ✓
Create and make copies of Sign in Sheet
Create directional signs to be posted outside in inside the building

Next Week:
Continue remaining prep tasks
Confirm interns/work study students support (some of them need reminders)
Post signs on Wednesday
Set up training room on Wednesday

Today you can request assistance for the prep tasks between now and next Wednesday (manual composition, etc) and the day of training (next Thurs and Fri) staff support from all work study students and interns. You can speak with Mike Jeffery about the works study students and he can make them available to you. Gwen of course can help you with the interns.So first find out when people are available this week and schedule them in.

I will not be in until 6pm tonight. I will review the manual and see what needs to be in place to be updated. I should have some instructions for you about the manual for Thursday.

Thanks Nicole!
Craig

- Did not get phone message
- Leave me an updated copy of the manual, so that I can have them copied
- Processed Kisha's credit card & sent her an email confirming her registration
- Sign in sheets for training - printed & saved in my files
- Binders have been ordered

Nicole Orlando

CDI 2008 Registration List

Kisha Thomas, LPC NCC
770-313-4661
kmax2000@bellsouth.net
— go to website, donate now, other $90
yes.
- mail out registration form
directions

John Williams
404.437.9866
Williams420@charter.net
Mobile not in service

Jennifer Smith
770.514.2745
yes. discussed not paying w/Claudia.
directions

Marquita Searcy
678.371.9693
* left message

Tracy Simpson
404.281.1698
- Not attending

- confirm attendance
- service provider? if not, register prior to 2/15/08 to ensure $90 workshop fee
- directions will be emailed

-404.589.9040 →
Craig Washington

Cultural Competency Training
Thursday Feb. 21 & Fri. Feb 22nd
9-5 pm on both days
at Positive Impact

[redacted]

Sustaining Donor - Donate Now

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Exploring Personal and Cultural Values:
A workshop for Positive Impact, Inc.
Presenter: Malcolm E. Anderson, Ph.D.

CULTURAL DIVERSITY INSTITUTE

Original

INTRODUCTIONS

Who's who???

Draw a Home

- Find a partner
- Use one (1) pen or pencil
- Use one (1) sheet of paper
- Together draw a picture of a home
- Do not talk about it
- Try not to direct each other (verbally or non-verbally)
- When you are finished look up and observe others quietly

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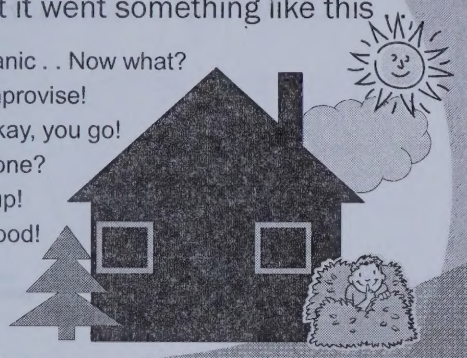
I bet it went something like this

- Panic . . Now what?
- Improvise!
- Okay, you go!
- Done?
- Yup!
- Good!

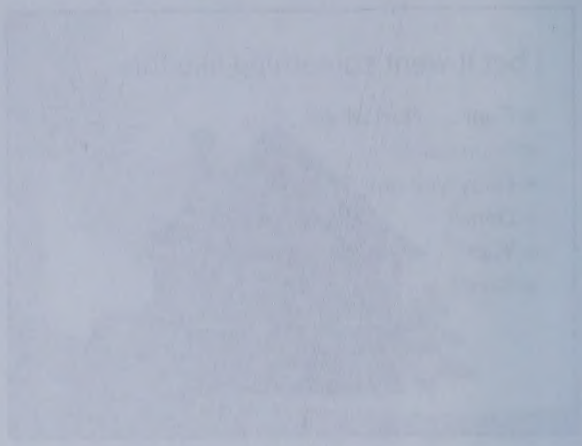


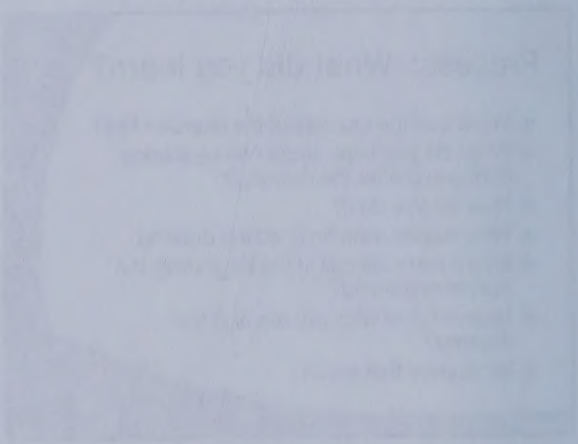
Process: What did you learn?

- What was the process of the exercise like?
- What did you think about before starting, during and after the drawing?
- How did you do it?
- Who started, who finished the drawing
- Was it more difficult in the beginning, the middle or the end?
- How much of who you are is in the drawing?
- What does that mean?

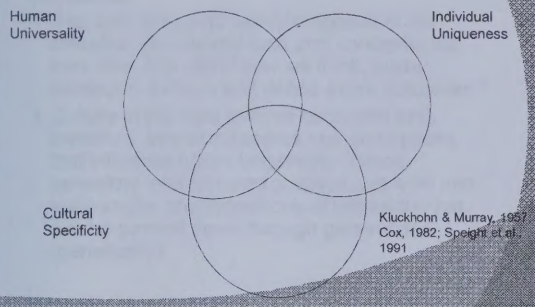
What's in the mix?

CULTURAL WORLDVIEWS AND PERSONAL VALUES





WORLDVIEW ORIENTATION



Worldviews

- Each group develops a distinct set of rules by which to view their world. This perception is then passed down in variation to other members of the group via socialization in the form of histories, story-telling, music, arts, rituals and other "customary ways of doing things."

Worldviews

- Cultural worldviews can be broadly defined to describe how a culture perceives its relationship/approach to the world (nature, institutions, other people, things, etc.)
- An individual who has grown up in a particular culture group develops his/her personal worldviews largely based on their cultural background and personal experiences.

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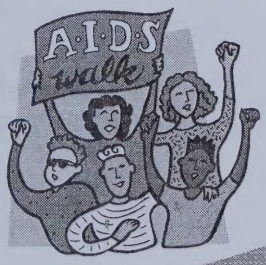
Worldviews

Sue and Sue (1999)

- "Not only are worldviews composed of our attitudes, values, opinions and concepts, but they also may affect how we think, make decisions, behave and define event outcomes."
- Culture in this light informs behaviors and, therefore, affects outcomes and perceptions that influence future behaviors. These behaviors later become adapted and form into traits and/or predispositions of behaviors that can be passed down through generations (genetically).

How do our worldviews and personal values effect our work with persons with HIV/AIDS?



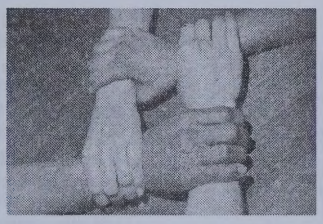
UNDERSTANDING CROSS-CULTURAL CONFLICTS IN TREATMENT:

Ways to avoid therapeutic impasse and increase treatment viability with persons with HIV/AIDS

Presented by: Malcolm E. Anderson, Ph.D.

How do we react/respond to persons with HIV/AIDS?

Understanding who we are is a good start!

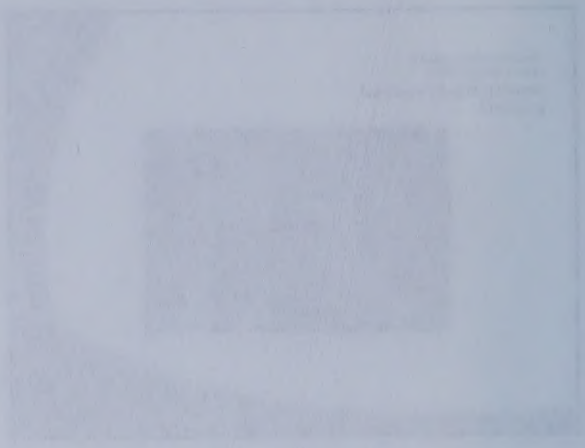


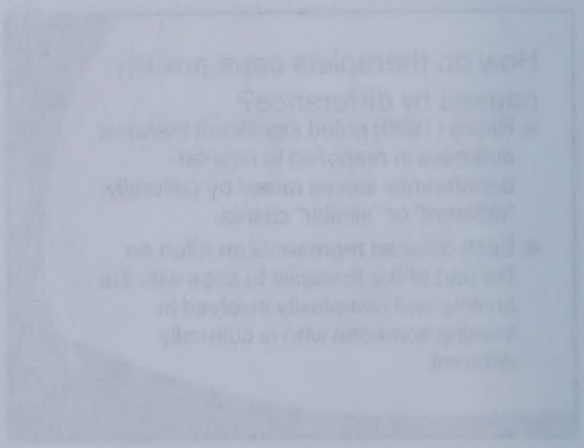
THE DOOR STEPS TO IMPASSE

THERAPIST'S DEFENSES

How do therapists cope anxiety caused by difference?

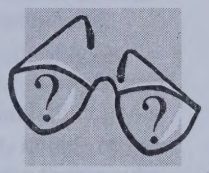
- Ridley (1995) noted significant therapist defenses in response to counter-transference issues raised by culturally "different" or "similar" clients.
- Each defense represents an effort on the part of the therapist to cope with the anxiety and complexity involved in treating someone who is culturally different.





Therapist's Defenses Ridley (1995)

- Culture blindness (overly absolutist)
- Culture consciousness (overly relativist)
- Cultural transference avoidance (non-empathic)
- Blind allegiance (too much empathy)
- Identification with the oppressor (blaming)

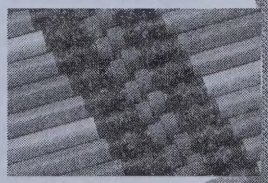


Cultural Blindness

- A defense that is initiated when differences become so overwhelming therapist's depend solely on commonalities between people and thus minimize cultural differences and unique cultural circumstances from case to case in an effort to remain "impartial and fair"

Cultural Encapsulation

- A defense that is initiated when differences become so overwhelming that they dominate *the way* therapist's see their patients. It renders one unable to see the commonalities between all people.



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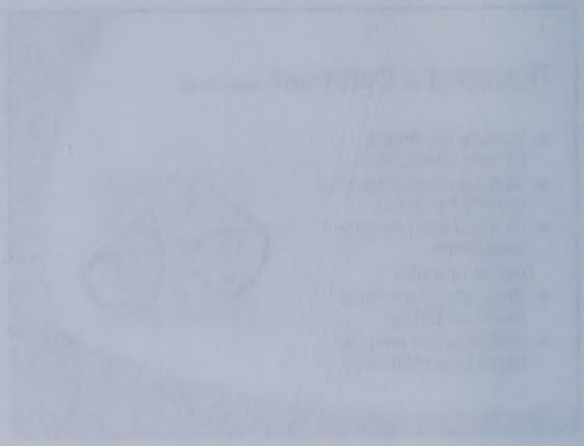

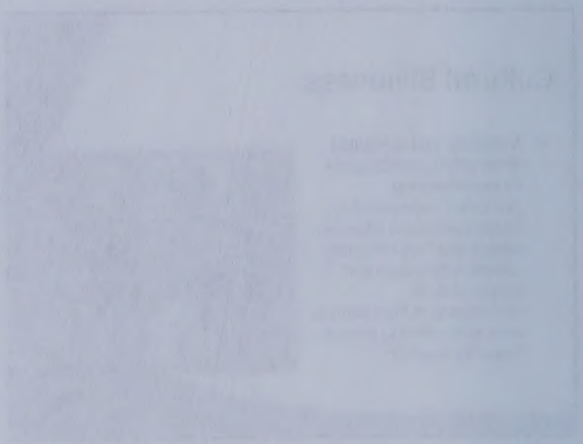

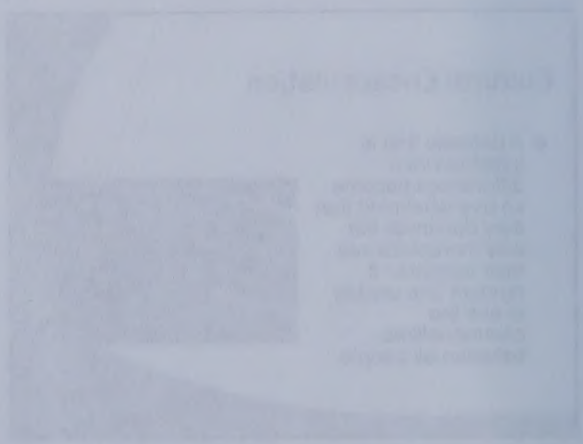

Impasse is . . . .

- A point of "stuckness", immobility, impotence, ineptitude, and/or circular movement with no advancement.
- Impasse sucks the life out of good therapy by rendering the therapist and the patient unable to reach their goals
- Impasse also negatively affects rapport and sabotages trust in the therapeutic relationship.

Impasse impedes decision-making

- Impasses are often reflected in miscommunication
- Impasses are experienced in power struggles
- Impasses are present in during periods of mis-information
- Impasses can be brought about via sexual attraction
- Impasses are often witnessed when there is cultural difference

Common Impasses

- Under bounded – the therapist is too far outside the client system to have in impact. The client or problem remains unchanged and relentlessly remains as the transactional linkage and focus (paucity of knowledge).
- Over bounded – the therapist finds themselves stuck in a role too inside the client system. This repetitious involvement creates a rigid, role defined position that allows limited maneuvering (counter-transference).

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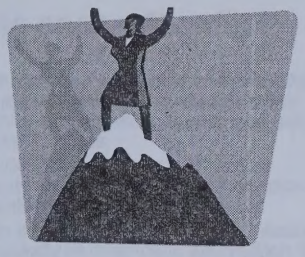


Interpersonal Struggles

Impasses are often unconscious and represent at times wishes or fantasies we have about our patients, how we envision therapy to be proceeding, or how we think the patient is benefiting from the treatment.

22

The impasse dilemma

- When confronted with an impasse the aware therapist generally works hard to contemplate action
- Often this action is though well thought out, presents a risk to the standard of care or to the moral, or ethical judgment of the therapist
- In turn, this action may present potential harm to the patient given it is exploratory and is triggered by the impasse

Failure to act on the impasse

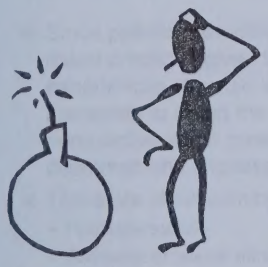
- May truncate the therapist's perceived spontaneity
- Reduce their creativity
- Call intuition into question
- Render the therapist feeling helpless
- Stunt progress and impede the patient's recovery.

(Pope, K.S., Sonne, J., and Holroyd, J. (1993)

Impasse causes conflict

- Because we often lack complete empathy and are prone to clinical guess work at times, we are often in conflict with patients who present as different from us.
- Cultural difference presents a greater opportunity for impasse as misunderstanding and misinterpretation are more likely.
- Added to the presence of cultural difference is the complexity of diagnostic information from which we often generalize conceptualizations treatment ideas to reduce the threat of difference.

So what do we do?



- Although there remains no sure, tested way to detect or resolve impasse, many therapists acknowledge that it is a process culminating over a series of sessions.

(Carter, 2004; Elkind, 1992; Omer, 2000)

How serious is this matter, really ?

Options to consider

- Consultation
- Literature review
- Introspection
- Supervision
- Begin or resume personal therapy

- Acknowledging short-comings is difficult
- I am left to integrate new material into existing knowledge
- I may have to face my level(s) of incompetence
- It may lead to other issues about me that I am not ready to face

Problems with these options?

Uh-Oh!

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Conflict jeopardizes treatment

- Once in conflict the therapeutic dyad becomes stymied and stagnant.
- Therapeutic progress is inhibited
- The therapist's competence becomes a focus of each member of the dyad
- Defenses begin to dominate the relationship and inhibit effective communication
- Alienation and isolation become apparent to both the therapist and the patient

A word about ethical relativism

- Since patients can differ widely in their moral practices given their different cultural experiences, it would seem practical for therapists to adopt the use of a relativist perspective when presented with ethical dilemmas and impasse.
- There are short-comings:
  - Homicide/suicide
  - Romantic or sexual attraction
  - Abuse and harm

The Interpersonal Grid

Pedersen (1985, 94)

- Type I relationships:
  - Two people have similar behaviors and similar expectations. High level of accuracy in both people's interpretations of one another's behavior.
- Type II relationships:
  - Two people have different behaviors but share the same expectations. High accuracy in intention but low level of accuracy because differences in behaviors are interpreted differently (cross-cultural conflict)

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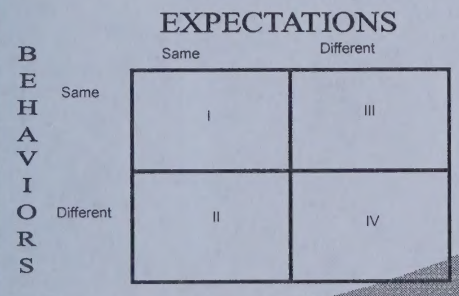
Interpersonal Grid continued

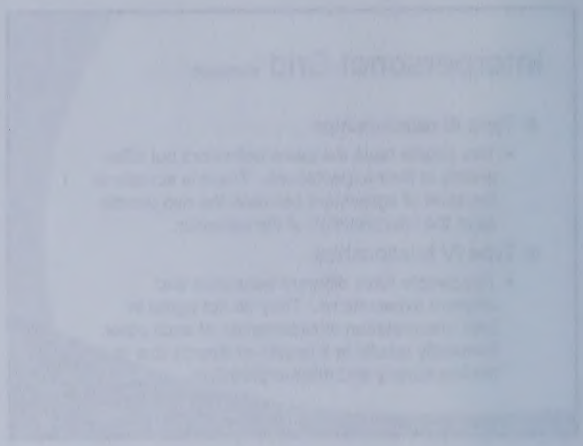
- Type III relationships
  - Two people have the same behaviors but differ greatly in their expectations. There is actually a low level of agreement between the two people as to the interpretation of the behavior.
- Type IV relationships
  - Two people have different behaviors and different expectations. They do not agree in their interpretation or expectation of each other. Generally results in a hostile exchange due to the inaccuracy and misinterpretation

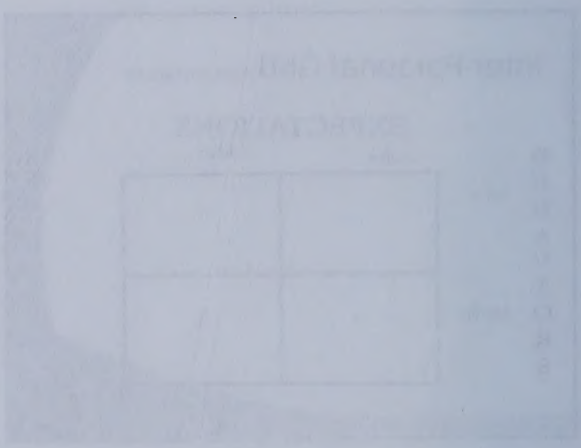
Inter-Personal Grid Pedersen (1985, 94)



A training module for mediating cross-cultural conflict

THE TRIAD MODEL





POSITIVE IMPACT INC.
Cultural Diversity Institute
May 20, 2010
9:30 AM – 4:00 PM

CULTIVATING CULTURAL COMPETENCE:
ENGAGING MULTIPLE IDENTITIES, CHALLENGING OPPRESSION, CREATING EFFECTIVE RESPONSES

AGENDA-DAY 1

9:00 AM – 9:30 AM	**Registration**
9:30 AM - 9:40 AM	**Welcome –Paul Plate**
9:40 AM –9:50 AM	**Overview of CDI – Sarah Lopez**
9:50 AM - 10:00AM	**"Up/Down Exercise" – Jo Lewis**
10:00 AM -11:30AM	**Panel: The Human Face of HIV- Perspectives from Helping Professionals** **Facilitator: Gwen Davies, Director of Clinical**
11:30 AM - 11:45 AM	**BREAK**
11:45 AM - 12:45 PM	**Oppression, Privilege and Micro-Aggression – Jo Lewis**
12:45 PM - 1:15 PM	**LUNCH**
1:15 PM – 2:15 PM	**Internalized Oppression and Addictions – Alan Graham**
2:15 PM - 2:30 PM	**BREAK**
2:30 PM – 3:30 PM	**Socio-cultural Influences and HIV/AIDS Among Latinos** **Sarah Lopez and Rosalinda Ramirez**
3:30 PM – 4:00 PM	**Closing Circle: Integration of Day 1 – Sarah Lopez**

POSITIVE IMPACT INC.

Cultural Diversity Institute
May 21, 2010
9:30 AM – 4:00 PM

CULTIVATING CULTURAL COMPETENCE:
ENGAGING MULTIPLE IDENTITIES, CHALLENGING OPPRESSION, CREATING EFFECTIVE RESPONSES

AGENDA-DAY 2

9:00 AM -9:30 AM	**Registration**
9:30 AM – 10:00 AM	**Review of Day 1; Opening Circle –Sarah Lopez**
10:00 AM -11:00 AM	**Exploring Personal & Cultural Values and Challenges – Arlene Noriega**
11:00 AM – 12:00 PM	**Cultural Competence: A Discussion – Arlene Noriega**
12:00 PM – 12:30 PM	**LUNCH BREAK**
12:30 PM – 2:00 PM	**Panel: Sexual Orientation and Spirituality: Paths Toward Integration** **Facilitator: Sarah Lopez**
2:00 PM – 2:15 PM	**BREAK**
2:15 PM – 3:30 PM	**Presentation of the Triad Model – Malcolm Anderson** ***Part I*: Understanding Who We Are and How We Respond to People Living with HIV/AIDS** ***Part II*: Skills Building for Human Service Providers**
3:30 PM – 4:00 PM	**Closing: Integration of the Self, the Other and the Work – Malcolm Anderson**

Education & Training Program

Cultural Diversity Institute

Thursday, May 20, 2010

9:30 am – 4:00 pm

NAME	ORGANIZATION	E-MAIL	PHONE	SIGNATURE	LUNCH
Andre Johnson	Positive Impact		(404) 589-9040		
Anthony Estelle	Positive Impact		(404) 589-9040		
Antoine Crosby	Positive Impact		(404) 589-9040		
Arlene Noriega, Ph. D	Rock Bridge Psychological Associates LLC				yes.
Ashley Taylor	Positive Impact		(404) 589-9040		
Brenda Edwards	Metro Atlanta Recovery Residences	Brenda.edwards@marrinc.com	(404)-392-1806		
Brian Tim Nix	Positive Impact Volunteer				
Carlos Amos	Positive Impact		(404) 589-9040		
Claudia Becerra	Positive Impact		(404) 589-9040		
Coti Perez-Espinoza	Positive Impact		(404) 589-9040		
Danny Sprouse	Positive Impact		(404) 589-9040		
Dr. Eli Budd	STAND INC/ Outreach	bebudd@bebuddphd.com	(404) 375-8114		
Francisco de la Fuente	Positive Impact		(404) 589-9040		
Glenn Fitch	Positive Impact		(404) 589-9040		

Education & Training Program

Cultural Diversity Institute

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Gwen Davies	Positive Impact		(404) 589-9040		
Harolyn Davis	Positive Impact		(404) 589-9040		
J. Alan Graham	Private Practice				
Jared Smiley	Positive Impact		(404) 589-9040		
Jeff Figueroa	Positive Impact		(404) 589-9040		
John Williams	Positive Impact		(404) 589-9040		
Karen Tringle	Positive Impact		(404) 589-9040		
Keanna Cheeley	Positive Impact		(404) 589-9040		
Kenneth D. Gantt	The Living Room INC.				
Kevin English	Positive Impact		(404) 589-9040		
Dr. Malcolm Anderson	Malcolm E. Anderson P.E.				
Mamie Jones	Positive Impact Volunteer	kelisleth@yahoo.com			
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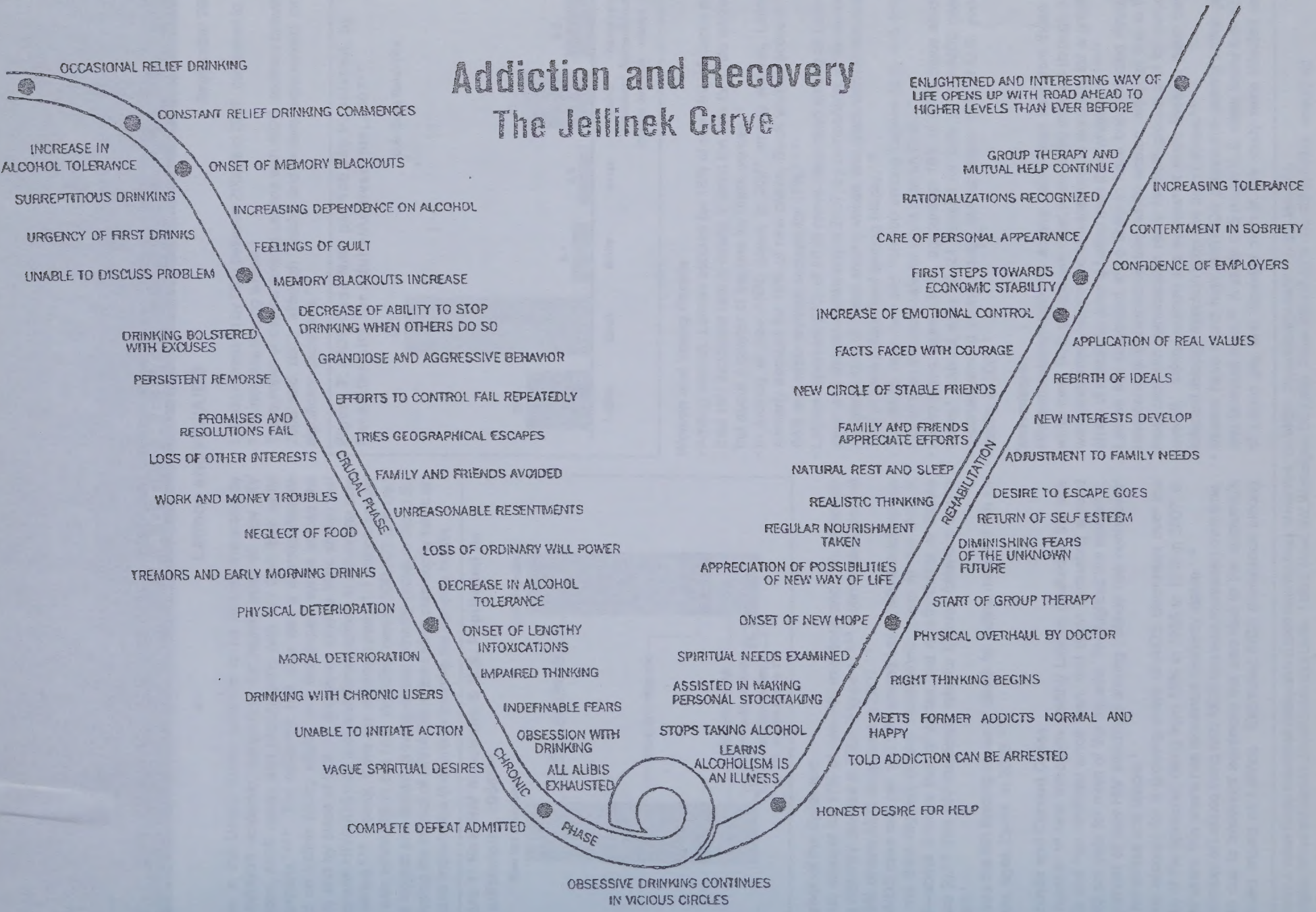
Addiction and Recovery
The Jellinek Curve



THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS POLICY

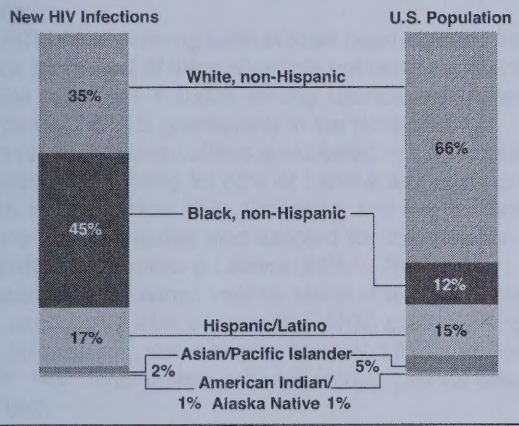
FACT SHEET

Latinos and HIV/AIDS

September 2009

Latinos in the United States continue to be heavily impacted by the HIV/AIDS epidemic, accounting for higher rates of new HIV infections, AIDS cases, and people living with HIV than their white counterparts.[1,2,3,4] The epidemic has also had a disproportionate impact on Latino young adults, and the impact varies across the country and by place of birth.[1,5] Moreover, studies have shown that Latinos with HIV/AIDS may face additional barriers to accessing care than whites.[6,7,8] Today, there are approximately 1.1 million people living with HIV/AIDS in the U.S, including nearly 200,000 Latinos.[4] As the largest and fastest growing ethnic minority group in the U.S., addressing the impact of HIV/AIDS in the Latino community takes on increased importance in efforts to improve the nation's health.

Figure 1: New HIV Infections & U.S. Population by Race/Ethnicity, 2006[2,3,9]



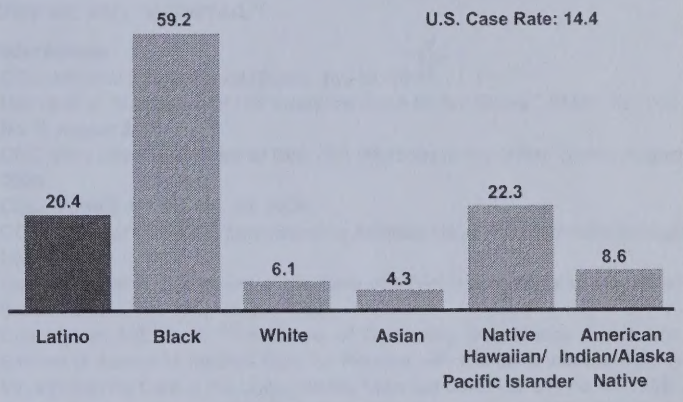
Snapshot of the Epidemic

- Latinos account for 17% of new HIV infections and 18% of people living with HIV disease in 2006 (Figure 1).[2,3,4] Latinos also account for 19% of new AIDS diagnoses in 2007.[1,10]
- The AIDS case rate per 100,000 among Latino adults/adolescents was the third highest of any racial/ethnic group in the U.S. in 2007—about 3 times that of whites, but one-third that of Blacks (Figure 2).[1,11] The HIV incidence rate for Latinos follows a similar pattern.[3]
- HIV was the 6th leading cause of death for Latino men and 5th for Latinas, ages 25–44, in 2006.[12]

Key Trends and Current Cases

- The number of new infections among Latinos peaked in the late 1980s and has declined since then, and been fluctuating around 10,000 per year for most of the decade. Throughout the epidemic, the number of new HIV infections among Latinos has been lower than for whites and Blacks.[3]
- Latinos account for a growing share of AIDS diagnoses over the course of the epidemic, rising from 15% in 1985 to 19% in 2007; in recent years, this share has remained relatively stable.[1,13]
- The number of Latinos living with AIDS has also increased over time, in part due to treatment advances but also due to the epidemic's continued impact on Latinos. Estimated AIDS prevalence among Latinos increased by 26% between 2003 and 2007, compared to an 18% increase among whites.[1]
- The number of deaths among Latinos with AIDS declined between 2003 and 2007, although Blacks and whites experienced more significant decreases.[1]

Figure 2: AIDS Case Rate per 100,000 Population, by Race/Ethnicity, for Adults/Adolescents, 2007[1,11]



Women and Young People

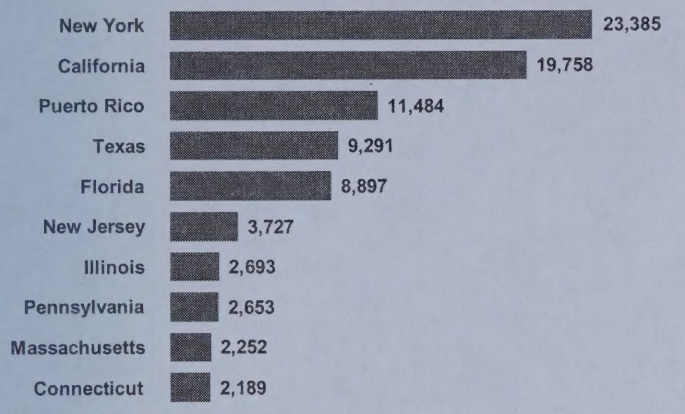
- Among women, Latinas account for 16% of new HIV infections and their HIV incidence rate is nearly 4 times the rate for white women, but about a quarter of the rate for Black women.[14]
- In looking at new AIDS cases in 2007 among women, Latinas similarly account for 15% of new cases; Black women account for 66% and white women account for 17%.[1,10,11]
- Latinas represent 21% of AIDS cases diagnosed among all Latinos (men and women combined) in 2007; by comparison, white women represent 15% of cases among whites, and Black women represent 36% of cases diagnosed among Blacks.[1,11]
- The AIDS case rate per 100,000 among Latinas (8.9) is 5 times higher than the case rate for white women (1.8).[1,11]
- Latino teens, ages 13–19, account for 19% of AIDS cases among teens.[5] Latinos ages 20–24 account for 24% of new AIDS cases reported among young adults, but represent 18% of U.S. young adults, in 2007.[5]

Transmission

- HIV transmission patterns among Latino men vary from those of white men. Both groups are most likely to be infected through sex with other men. Heterosexual transmission accounts for a greater share of infections among Latino men than white men.[1,14,15]
- Latinas are somewhat more likely to have been infected through heterosexual transmission than white women, although this is the most common transmission route for both groups and for women overall. White women are somewhat more likely to have been infected through injection drug use than Latinas.[1,14]
- Studies have found high HIV/AIDS prevalence among Latino gay and bisexual men.[16] A study in 5 major U.S. cities found that 17% of Latino gay and bisexual men in the study were infected with

HIV. Prevalence among white gay and bisexual men was 21% and 46% among Black gay and bisexual men, the highest of any group.[17] Knowledge of HIV status among those already infected is also very low.[16] In addition, newly infected Latino gay and bisexual men are younger than their white counterparts, with those ages 13–29 accounting for 43% of new infections among Latino gay and bisexual men compared to 25% among whites.[14]

Figure 3: Number of Latinos Estimated to be Living with AIDS, Top 10 States/Areas, 2007[18]



Geography

Although AIDS cases among Latinos have been reported throughout the country, the impact of the epidemic is not uniformly distributed:

- AIDS case rates per 100,000 among Latinos are highest in the eastern part of the U.S., particularly in the Northeast.[18]
- AIDS prevalence among Latinos is clustered in a handful of states, with 10 states accounting for 88% of Latinos estimated to be living with AIDS in 2007. New York, California, and Puerto Rico top the list (Figure 3). Ten states also account for the majority of newly reported AIDS cases among Latinos (83% in 2007).[18,19]
- AIDS cases among Latinos vary by place of birth. Latinos born in the U.S. account for 41% of estimated AIDS cases among Latinos in 2007, followed by Latinos born in Mexico (23%) and Puerto Rico (20%).[1,20] HIV transmission patterns among Latinos also vary by place of birth.[1]

Access to and Use of the Health Care System

The HIV Cost and Services Utilization Study (HCSUS), the only nationally representative study of people with HIV/AIDS receiving regular or ongoing medical care for HIV infection, found that Latinos fared more poorly on several important measures of access and quality, differences that diminished over time but were not completely eliminated.[6] In addition, HCSUS found that Latinos were more likely to report postponing medical care due to factors such as lack of transportation.[7] Latinos were also more likely than whites to delay care after their HIV diagnosis.[8]

Health Insurance

Having health insurance, either public or private, improves access to care. Insurance coverage of those with HIV/AIDS varies by race/ethnicity, as it does for the U.S. population overall.

- The HCSUS study found that Latinos with HIV/AIDS were more likely to be publicly insured or uninsured than their white counterparts, with half relying on Medicaid compared to 32% of whites. Approximately one quarter of Latinos with HIV/AIDS (24%) were uninsured compared to 17% of whites. Latinos were also about half as likely to be privately insured than whites (23% compared to 44%).[21]
- Insurance status also varies at the time of HIV diagnosis. Analysis of data from 25 states between 1994 and 2000 found that Latinos were less likely than whites to have private coverage and more likely to be covered by Medicaid at the time of their HIV diagnosis. A third of Latinos were uninsured at the time of their diagnosis, higher than other groups.[22]

HIV Testing

- Among the U.S. population overall, Latinos are more likely than whites to report having been tested for HIV in the last 12 months (28% compared to 14%).[23]
- Among those who are HIV positive, CDC data indicate that four in 10 Latinos (41%) were tested for HIV late in their illness—that is, diagnosed with AIDS within one year of testing positive (in those states/areas with HIV name reporting); by comparison, 35% of Blacks and 34% of whites were tested late.[1]

Concern About HIV/AIDS

- A recent survey found that Latinos express concern about HIV/AIDS. While only one in 10 Latinos named it as the most urgent health problem facing the nation, more than one-third named it as a more urgent problem for their community than it was a few years ago.[23]
- One in four Latinos say they are personally very concerned about becoming infected with HIV, a proportion that has declined since the mid-1990's. Latino parents are more concerned about a son or daughter becoming infected with HIV, with four in 10 (39%) reporting they are very concerned.[23]

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[8] Turner BJ et al. "Delayed Medical Care After Diagnosis in a U.S. Probability Sample of Persons Infected with the Human Immunodeficiency Virus." *Archives of Internal Medicine,* Vol. 160; 2000.
[9] U.S. Census Bureau. 2006 Population Estimates.
[10] Calculations based only on cases for which race/ethnicity data were provided.
[11] Includes reported cases among those 13 years of age and older. Estimates do not include cases from the U.S. dependencies, possessions, and associated nations, and cases of unknown residence.
[12] CDC. *Slide Set: HIV Mortality* (through 2006).
[13] CDC. Special Data Request; 2006.
[14] CDC. *MMWR,* Vol. 57, No. 36; 2008.
[15] CDC. *Slide Set: HIV/AIDS Surveillance by Race/Ethnicity* (through 2007).
[16] CDC. *Fact Sheet: HIV/AIDS Among Men Who Have Sex with Men;* June 2007.
[17] CDC. *MMWR,* Vol. 54, No. 24; 2005.
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[19] Estimates include U.S. dependencies, possessions, and associated nations, and cases of unknown residence.
[20] Calculations based only on cases for which data by place of birth were provided.
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This publication (#6007-07) is available on the Kaiser Family Foundation's website at www.kff.org.

Exploring Personal and Cultural Values:
A workshop for Positive Impact, Inc.
Presenter: Malcolm E. Anderson, Ph.D.

CULTURAL DIVERSITY INSTITUTE

INTRODUCTIONS

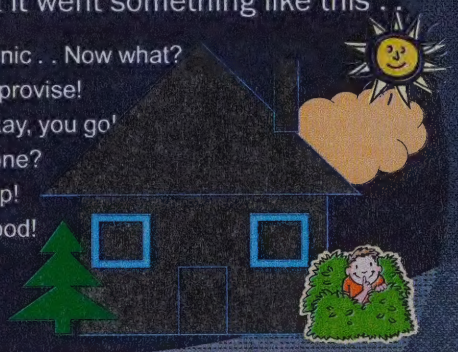
Who's who???

Draw a Home

- Find a partner
- Use one (1) pen or pencil
- Use one (1) sheet of paper
- Together draw a picture of a home
- Do not talk about it
- Try not to direct each other (verbally or non-verbally)
- When you are finished look up and observe others quietly

I bet it went something like this . . .

- Panic . . Now what?
- Improvise!
- Okay, you go!
- Done?
- Yup!
- Good!



Process: What did you learn?

- What was the process of the exercise like?
- What did you think about before starting, during and after the drawing?
- How did you do it?
- Who started, who finished the drawing
- Was it more difficult in the beginning, the middle or the end?
- How much of who you are is in the drawing?
- What does that mean?

What's in the mix?

CULTURAL WORLDVIEWS AND PERSONAL VALUES

Copyright to Dr. Malcolm E. Anderson, P.C.

INTRODUCTIONS

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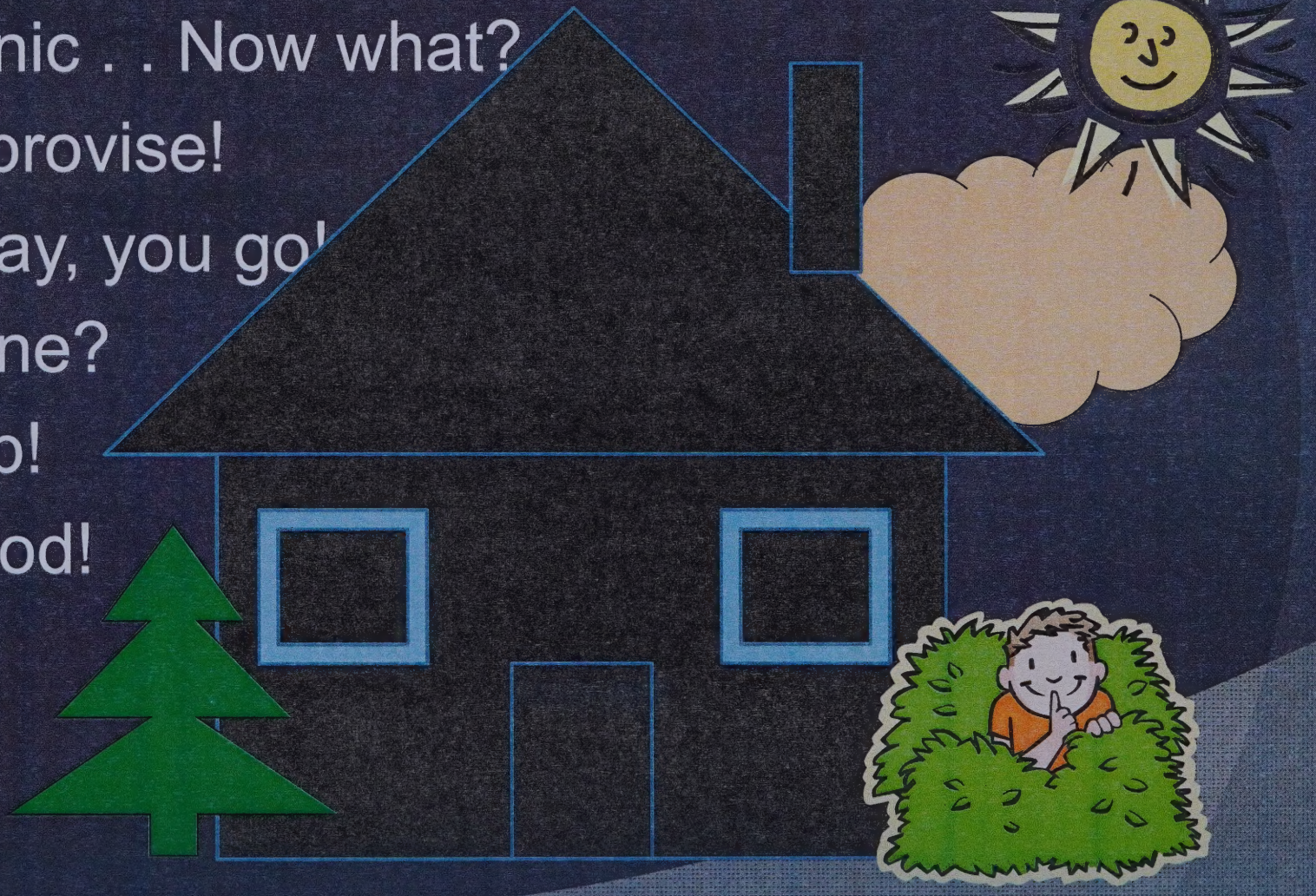

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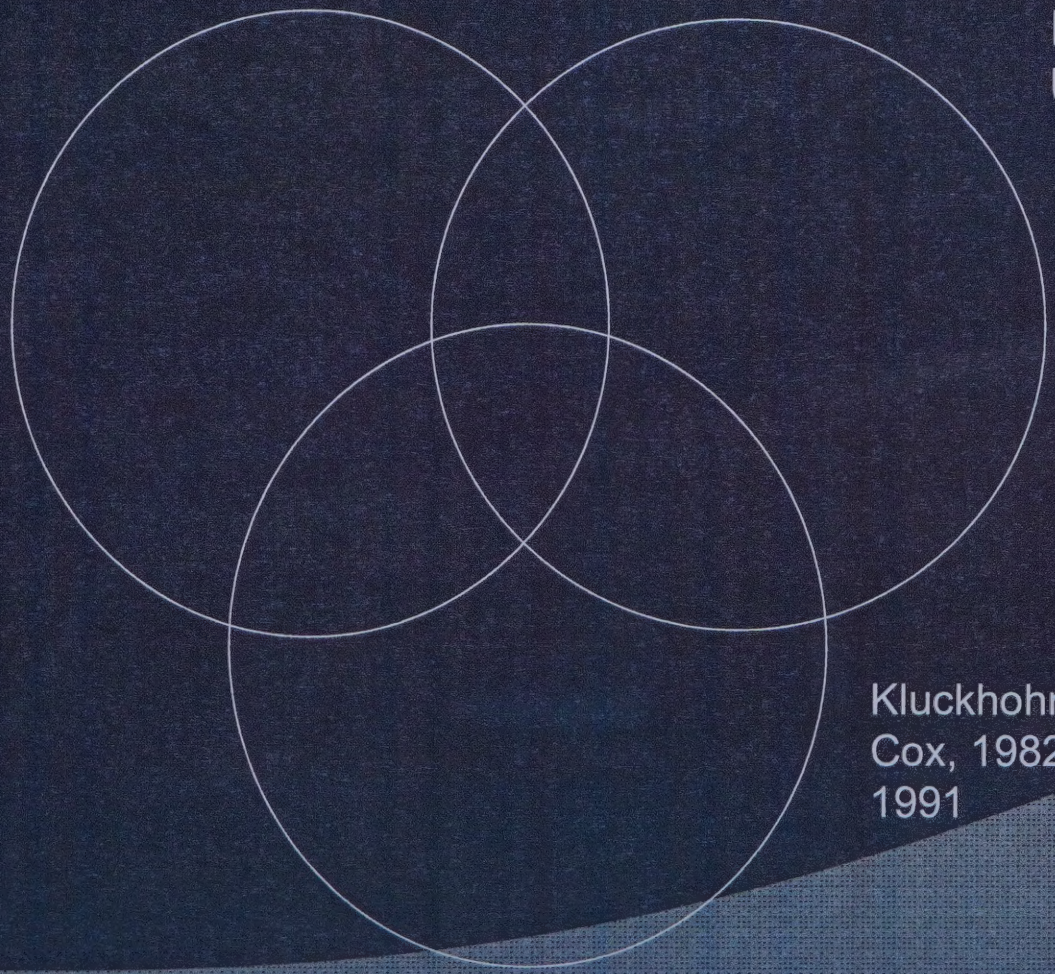
CULTURAL WORLDVIEWS AND PERSONAL VALUES

WORLDVIEW ORIENTATION

Human Universality

Individual Uniqueness



Cultural Specificity

Kluckhohn & Murray, 1957; Cox, 1982; Speight et al., 1991

Worldviews

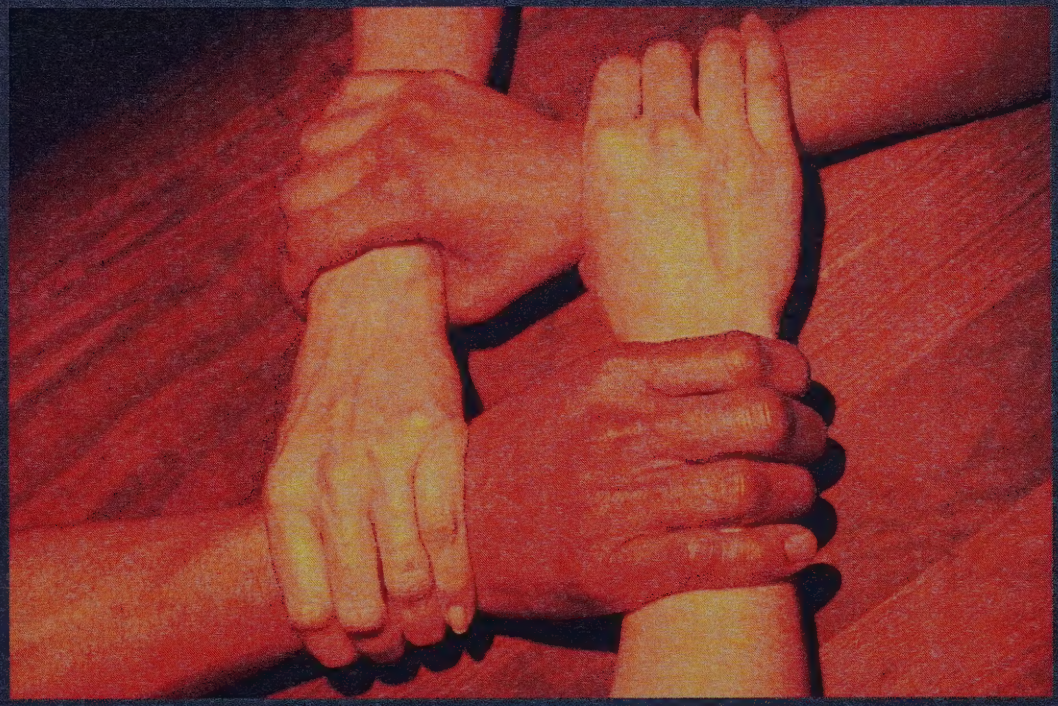
- Each group develops a distinct set of rules by which to view their world. This perception is then passed down in variation to other members of the group via socialization in the form of histories, story-telling, music, arts, rituals and other "customary ways of doing things."

Worldviews

- Cultural worldviews can be broadly defined to describe how a culture perceives its relationship/approach to the world (nature, institutions, other people, things, etc.)
- An individual who has grown up in a particular culture group develops his/her personal worldviews largely based on their cultural background and personal experiences.

How do we react/respond to persons with HIV/AIDS?

Understanding who we are is a good start!



THE DOOR STEPS TO IMPASSE

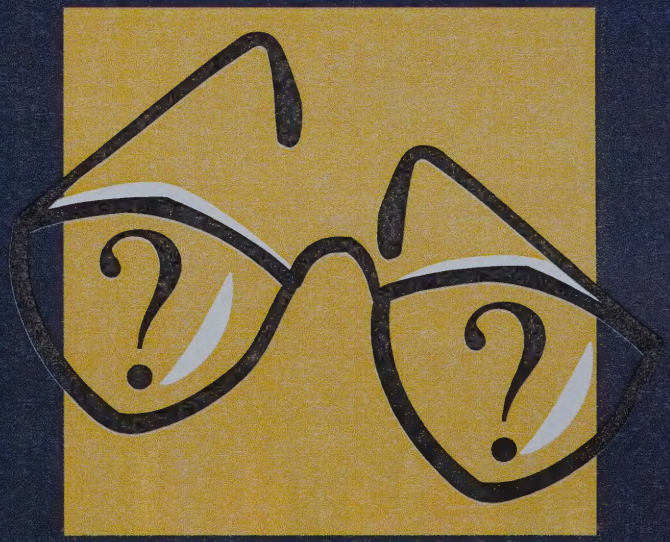
THERAPIST'S DEFENSES

How do therapists cope anxiety caused by difference?

- Ridley (1995) noted significant therapist defenses in response to counter-transference issues raised by culturally "different" or "similar" clients.
- Each defense represents an effort on the part of the therapist to cope with the anxiety and complexity involved in treating someone who is culturally different.

Therapist's Defenses Ridley (1995)

- Culture blindness (overly absolutist)
- Culture consciousness (overly relativist)
- Cultural transference avoidance (non-empathic)
- Blind allegiance (too much empathy)
- Identification with the oppressor (blaming)



Cultural Blindness

- A defense that is initiated when differences become so overwhelming therapist's depend solely on commonalities between people and thus minimize cultural differences and unique cultural circumstances from case to case in an effort to remain "impartial and fair"

Cultural Encapsulation

- A defense that is initiated when differences become so overwhelming that they dominate *the way* therapist's see their patients. It renders one unable to see the commonalities between all people.

Impasse is . . . .

- A point of "stuckness", immobility, impotence, ineptitude, and/or circular movement with no advancement.
- Impasse sucks the life out of good therapy by rendering the therapist and the patient unable to reach their goals
- Impasse also negatively affects rapport and sabotages trust in the therapeutic relationship.

Common Impasses

- Under bounded – the therapist is too far outside the client system to have in impact. The client or problem remains unchanged and relentlessly remains as the transactional linkage and focus (paucity of knowledge).
- Over bounded – the therapist finds themselves stuck in a role too inside the client system. This repetitious involvement creates a rigid, role defined position that allows limited maneuvering (counter-transference).

Interpersonal Struggles

Impasses are often unconscious and represent at times wishes or fantasies we have about our patients, how we envision therapy to be proceeding, or how we think the patient is benefiting from the treatment.

The impasse dilemma

- When confronted with an impasse the aware therapist generally works hard to contemplate action
- Often this action is though well thought out, presents a risk to the standard of care or to the moral, or ethical judgment of the therapist
- In turn, this action may present potential harm to the patient given it is exploratory and is triggered by the impasse

Failure to act on the impasse

- May truncate the therapist's perceived spontaneity
- Reduce their creativity
- Call intuition into question
- Render the therapist feeling helpless
- Stunt progress and impede the patient's recovery.

(Pope, K.S., Sonne, J., and Holroyd, J. (1993)